MEDICARE: THE NEED FOR REFORM

HEARING

BEFORE THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

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MEDICARE: THE NEED FOR REFORM

WEDNESDAY, JULY 25, 2001

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, DC.

The committee met, pursuant to call, at 10 a.m. in room 210, Cannon House Office Building, Hon. Jim Nussle (chairman of the committee) presiding.

Members present: Representatives Nussle, Gutknecht, Collins, Fletcher, Watkins, Culberson, Spratt, McDermott, Bentsen, Clayton, Hooley, Baldwin, and Holt.

Chairman NUSSLE. Well, good morning. This is the full committee hearing, Budget Committee, on Medicare and the need for reform.

Earlier this year when the committee first met we, I believe, had a fantastic bipartisan discussion about the role of the Budget Committee and where, in fact, the Budget Committee should be taking the Congress, leading in a new direction. So much of the first charter of the Budget Committee, and particularly during the reforms of the 1980's, was to get us out of the deficit, get us out of the chronic deficits that our country faced and that the Budget Committee, by and large, was the fire department. You know, you pull the alarm and we arrived and sometimes we put the fire out, sometimes we made it worse. Our heart was in the right place, but there was no question that we were looking at the short term. We were not looking at fire prevention in the future.

And one of the biggest fires that is out there on the horizon are obligations that the Federal Government is making today, writing checks that we can't cash possibly in the future.

Our entitlement programs, as we learned during the reform discussion of the last couple of weeks, are gobbling up just about every portion of the tax dollars, the surplus and future obligations for our budget. Now the entitlement programs, Social Security, Medicare, Medicaid, a number of welfare-type programs, assistance programs, are becoming the largest growing, fastest growing, and now the largest part of our Federal budget.

And so one of the things that Ranking Member Spratt and myself, Mark Kirk, Ernie Fletcher, and a number of others—I do not mean to leave people out—but a number of people said we ought to start focusing on the long term. Let us take a little longer horizon. We always look at Medicare for what it is going to do next week, next month, next year, but we very rarely look at what happens at 2016 and beyond.

That is the purpose of the hearing today, to talk about what we can do in order to deal with what we know is a certainty; and that is that we have a program that is a very important program to the seniors of this Nation, not only the seniors today, but the seniors of the future of which we all count ourselves in. By the time we are seniors, it will be the Budget Committee that will have to grapple with the fact that we didn't make the reforms necessary today in order to deal with the future that we know is coming.

We have an opportunity to make those changes. And I always point this out, because being from a rural area in particular, I am very concerned about the way health care is delivered, the way the Medicare system works in my State of Iowa. Just to give you an example, Iowa ranks the third highest in population of seniors 65 years and older. We are the second highest population of seniors 75 years and older. And now we are number one when it comes to the population of seniors 85 years and older. That is just in Iowa. And yet we rank 50th in the country when it comes to Medicare reimbursement overall. That is not fair to our seniors. That doesn't sound to me like a program that is working. That is just the one hand.

I go out and I talk to my hospitals, I talk to my doctors, I talk to folks who have to rely on these reimbursements in order to provide and deliver the health care product in a quality way. They do a great job and they have always done a great job in providing that kind of quality product. But they tell us not only is the reimbursement low—and that is one focus and they are happy that we are focusing on that—but they tell us the regulatory burden is just unimaginable.

I was in a meeting here not too long ago where just for one patient for a 2-day stay at the hospital, they rolled out a document. They taped it all together so you could see all the pieces of paper that they had to fill out. The nurse who is there to provide care, is now becoming a secretary and a clerk, which is absolutely not what they went to school for. And this piece of paper started from about where I am and went to the back of the room here in length. That was just for one patient, for one stay. And the question came up, "who reads this?" of course, nobody reads this. It is spot checked. But the paperwork burden, the regulatory burden on our providers is not delivering quality health care. And that is also burdening this health care system.

We know from the testimony from our very first witness here today, that the agency that provides Medicare as well as the contractors that deliver the health care product aren't getting their questions answered correctly from what was HCFA—now what are you called now? What is HCFA called now? Center for Medical Services—is that right—Medicare and Medicaid Services. It was easier when the Secretary came up and said he was going to call it Momma. That was a lot easier to remember. But we didn't call it Momma.

The point is that the name change is good, but there are many things within the agency that need to be reformed. And that is part of what we are also going to be talking about today, the way that they might impact our long-term focus.

I didn't mean to start without you, Mr. Spratt, but the focus of this hearing is to look at the long term. We have an opportunity today to begin looking at a much longer horizon. We always look at tomorrow and the next month. We decided—you and I decided, the committee decided—that we were going to try and change the focus for the committee this year and take a little longer-term approach to this. And we have got some great panels to talk about this.

The first one today that is going to talk about this is the Comptroller General, who is here today from the General Accounting Office, David Walker, who has spoken to our committee on a number of occasions. We welcome you back and appreciate the opportunity to visit with you about the serious problem that Medicare has and its long-term financial stability.

Our second panel, we will have Frank Pallone, Member of Congress and also the co-chairman of the Democratic Task Force on Health Care Reform. From New Jersey, Rubin Jose King-Shaw, who is Deputy Administrator, Centers for Medicare and Medicaid Services, CMS. And Bill Scanlon who is the Director of Health Care issues for the General Accounting Office.

These three will focus on Medicare's regulatory and bureaucratic structures in the areas for possible regulatory reform and how that could impact long-term stability for Medicare.

And then, finally, panel III, we have Gary Kaplan, who is a doctor from Kentucky—Lexington, Kentucky. We have Marilyn Moon, Senior Fellow from the Urban Institute. And these witnesses will discuss the effect on providers of the regulatory burden and the bureaucracy they face.

I think the good news that we have got today is that there is a bipartisan desire to make sure that Medicare is modernized so it can deliver a quality product for seniors for many years to come. We may disagree slightly on exactly how we are going to get there, but I know the desire is one that is shared. The Budget Committee has a responsibility, now that we are out of the chronic deficits, to take a longer-term horizon, longer-term approach to these issues. This was a good idea. To begin holding these kinds of hearings. I credit Mr. Spratt and other members for the idea, and we look forward to the testimony of our witnesses.

Mr. Spratt.

Mr. SPRATT. Let me say to all our witnesses, to General David Walker in particular, thank you for your interest, thank you for your commitment in coming. This is a gravely important subject and we appreciate your participation.

Chairman NUSSLE. With that, we will turn—let me ask unanimous consent that all members have 7 days to submit written statements, opening statements in the record at this point. Without objection, so ordered.

[The prepared statement of Mr. Matheson follows:]

PREPARED STATEMENT OF HON. JIM MATHESON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF UTAH

Thank you, Chairman Nussle and Ranking Member Spratt, for holding this hearing today to examine the need for Medicare reform. I believe this is a very important issue that affects all of our constituents. Medicare needs to be reformed to en-

sure long-term solvency for current and future generations, provide a modern benefit plan for seniors, and to improve program management.

Since its creation in 1965, the Medicare program has provided a vital source of health coverage for many seniors and disabled individuals who could have otherwise faced significant challenges in obtaining insurance. Medicare now provides health insurance for around 40 million people nationwide, but this population is expected to double over the next thirty years with the impending retirement of the baby boomer population.

We must take the necessary actions now to ensure the program's solvency for current and future generations. Now more than ever, it is important for Congress to make prudent fiscal decisions to protect the current Medicare surpluses. As members of the Budget Committee, we have a responsibility to ensure that any legislation passed by Congress does not dip into these surpluses.

Medicare's current benefit structure includes coverage for the costs of many acute care services; however, it has very limited preventive and prescription drug benefits. I believe it is important that we reform the Medicare program so that beneficiaries receive a more modern benefits package, including prescription drug coverage and preventive benefits.

I support adding a voluntary prescription drug benefit under Medicare to help seniors meet their medication needs. Unlike medical care thirty years ago when Medicare was created, prescription drugs are now an integral part of modern day medical treatment. This additional coverage would help ensure that seniors with fixed incomes are better able to fill their prescriptions without having to choose between medicine and food, energy costs, and other essential expenses.

I support adding preventive benefits under Medicare to help seniors take steps to prevent diseases. Early detection and prevention are critical elements in helping seniors maintain a longer, healthier lifestyle. Simple screening tests to detect high cholesterol and blood pressure, nutrition counseling, and other benefits are not currently covered by Medicare. I believe we must modernize the program in a fiscally prudent manner so that we can include important early detection and preventive benefits.

We must take additional steps to improve Medicare's management structure. Since being elected to Congress, I have heard from a number of health care providers and Medicare beneficiaries regarding the need to reform the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration). I have met with many Utah physicians, nurses, hospital administrators, home health agencies, laboratories, and other health professionals who have indicated that the current system is often burdensome and duplicative, making it difficult for them to devote all of their efforts to ensuring quality health care. I share the concerns of my constituents regarding this important issue, and I have cosponsored legislation designed to make necessary management reforms so that the focus of Medicare is on patient care rather than burdensome paperwork.

I appreciate the recent steps that Health and Human Services Secretary Tommy Thompson has taken to improve CMS, and I look forward to Congress and the administration working together in a bipartisan fashion to make additional improvements.

Again, I thank Mr. Nussle and Mr. Spratt for holding this hearing today, and I look forward to working with my colleagues on the Budget Committee to meet all of the challenges facing the Medicare program.

Chairman NUSSLE. And now we turn to you Mr. Walker, as the head of the General Accounting Office, Comptroller General. We want to look at Medicare and we want to look at the long-term stability of Medicare. We will put your entire testimony in the record, and it is quite lengthy and we appreciate that. It has quite a bit of substance and charts. And we appreciate the fact—what I would invite you to do is to summarize and to hit the high points that you think we should pay attention to as we examine your testimony. And then we will have some questions for you.

Mr. Walker.

STATEMENT OF HON. DAVID M. WALKER, COMPTROLLER GENERAL OF THE UNITED STATES

Mr. WALKER. Thank you, Mr. Chairman and other members of the committee. It is a pleasure to be here today to speak with you about the long-range financial condition of the Medicare program.

Mr. Chairman, as you noted, if we look at our current fiscal situation, it is clear that our challenges are not immediate. However, they are on the horizon, and I think that my testimony will dramatically demonstrate that today. Although the short-term outlook for Medicare's Hospital Insurance Trust Fund improved somewhat from last year, the long-term projections are much worse due to a change in expectations about future health care costs. Specifically, the Medicare trustees' latest projections released in March incorporate higher assumptions about the long-term growth in health care spending. As a result, the long-term outlook for Medicare's financial future, both the HI Hospital Insurance Part A Trust Fund and the SMI Part B Trust Fund is considerably worse than previously estimated.

The Congressional Budget Office also increased its long-term estimates of Medicare spending. The slowdown in Medicare spending growth that we have recently seen appears to have come to an end. In the first 8 months of fiscal 2000, Medicare spending was 7.5 percent higher than the previous year. The fiscal discipline imposed by the Balanced Budget Act of 1997 continues to be challenged, while the interest in modernizing the Medicare benefits package to include prescription drug coverage has increased. Taken together, these developments mean higher, not lower, health care cost growth. They reinforce the need to begin taking steps to address the challenges associated with meaningful Medicare reform.

In pursuing such reform, it is important to focus on the long-term sustainability of the combined Medicare program rather than the solvency of the HI Trust Fund alone. Ultimately, any comprehensive Medicare reform must confront several fundamental challenges.

In summary, Medicare spending is likely to grow faster than previously estimated.

Secondly, as our first chart shows, based upon GAO's most recent long-term budget simulation, known demographic trends and rising health care costs are likely to drive us back into a period of escalating deficits and debt, absent meaningful reform. Basically, what this chart shows is if you assume that the tax rate as a percentage of GDP, as a percentage of the overall economy, stays roughly the same over the next 50 years—and this is after considering certain recent actions by the Congress—and if you consider that Congress saves every penny of the Social Security surplus, but either through tax cuts, spending increases or some combination thereof, spends the on-budget surplus, then this is what the future looks like based upon the best estimate assumptions of the Social Security and Medicare trustees.

These represent point-in-time estimates, and obviously you move progressively from one point in time to the other. But if you take 2030, once we pay Social Security, Medicare, and Medicaid, you have to either cut all other spending by 50 percent or raise taxes by 25 percent. And this is just at the Federal level. Or by the year

2050, the deficits escalate so quickly, primarily due to entitlement programs, you either have to double taxes or cut total spending by 50 percent. And this considers the increased assumptions by both CBO and OMB in the rate of productivity growth which were underlying their last projections.

This simulation does not, however, consider any updates to CBO's projections that are forthcoming in the near future, hopefully, within the next month or so.

Medicare sustainability can no longer be measured merely by using the traditional measure of HI Trust Fund solvency. The financial status of this trust fund does not reflect the whole picture. In fact, focusing on HI solvency alone can be misleading and can give a false sense of security regarding the overall condition of the Medicare program.

Cash flow is key. Whether you are a business, whether you are a family or an individual, or whether you are a government program, cash flow is key. If you just look at Part A alone, this demonstrates what the cash flows will be in that program. You can see that right now, we are experiencing positive cash flows. But in the year 2016, it is projected to turn negative and it gets progressively worse. This does not consider the SMI program. This does not consider any prescription drug benefit. Cash flow is very important.

I might also point out that based upon the Medicare and Social Security trustees' latest estimates, the Social Security Trust Fund is expected to turn negative cash flow in 2016 as well.

Both Part A expenditures which are financed through payroll taxes and Part B SMI expenditures which are financed through general revenues and beneficiary premiums should be taken into consideration. When viewed from this comprehensive perspective, total Medicare spending is projected to double as a percentage of the economy by 2035. Importantly, this estimate does not include any prescription drug benefit. Since the cost of the drug benefit would boost these spending projections even further, adding prescription drug coverage will require difficult policy choices that will likely have significant effects on beneficiaries, taxpayers and the program.

Recognition of who bears the cost of Medicare is critical. Currently, there may not be full awareness among the public and others that payroll tax contributions and premiums do not finance current Medicare benefits. In other words, virtually everybody gets a real good deal on Medicare. Hardly anybody is paying for their Medicare benefits.

Properly structured reforms to promote competition among health plans can help make beneficiaries more cost conscious. However, improvements to traditional fee-for-service Medicare are also critical, as it will likely remain dominant for some time to come.

Fiscal discipline is difficult, but the continued importance of traditional Medicare underscores the need to base adjustments to provide payments to providers based on hard evidence rather than anecdotal information, and to carefully target relief both where it is needed and deserved.

From a similar standpoint, reform of Medicare's management, which is on the table as discussions of Medicare program reforms proceed, will require carefully targeted efforts to ensure that ade-

quate resources are properly coupled with improved performance and increased accountability.

Ultimately, we will need to look at broader health care reforms to balance health care spending with other societal priorities. It is important to look at the entire range of Federal policy tools, tax policy, spending and regulation. It is also important to note the fundamental differences between health care wants, which are virtually unlimited, from needs, which should be defined and hopefully can be addressed, and overall affordability of which there is a limit.

In the end, Congress will need to take a range of steps along with the administration to increase the transparency of health care costs and quality, target assistance to those in need, reexamine related tax incentives, and assure accountability for desired outcomes. The consensus is that Medicare is likely to cost more than previously estimated, and therefore that serves to reinforce the need to act sooner rather than later.

The next chart demonstrates the cost of delay. The next chart shows that if Congress were to take steps today, then you would either have to reduce benefits by 37 percent or increase the payroll tax by 60 percent in order to deal with just Part A alone. If you wait until 2016 when you experience a negative cash flow in that program, obviously you have a higher benefit reduction and higher tax increase that would be necessary. And if you delay even further, it escalates.

Importantly, the situation gets worse year by year. These are based upon a 75-year projection, the so-called "cliff effect." Remember when Columbus sailed the ocean blue? The debate was whether the Earth was flat or round. We now know the Earth is round. Unfortunately on these projections, they assume that the Earth is flat in year 2075, when in reality the deficit in 2075 is much worse than that far-right column, and gets worse every year. As a result, we must recognize that the longer we delay, the tougher it is going to be, because the more people will be enfranchised and the more significant the change will have to be.

In addition, efforts to update the program's benefit package will need to be carefully considered and obviously openly deliberated.

As the Congress considers Medicare reform, it will be important to adopt effective cost containment reforms alongside potential benefit expansions. Any benefit expansion efforts hopefully will be coupled with adequate program reforms, in order for Medicare's long-term financial condition not to be worsened. This is especially important in connection with potential prescription drug coverage, as this coverage represents the fastest growing health care expenditure for most public and private sector plans. Therefore, the time to begin to address the Medicare challenge is now.

Obviously, incremental steps will be necessary. Candidly, the financial challenges associated with Medicare are multiple times greater than Social Security. The expectation gap associated with Medicare is much greater than Social Security. In Social Security, you have an opportunity to exceed the expectation of all generations of Americans, because current retirees and near-term retirees are not expecting they are going to get all their benefits, when in reality they probably will when you act.

Secondly, baby boomers like myself and Generation X-ers and Y's, like my children, are discounting what they think they are going to get, in some cases discounting more than they should. This Congress has the opportunity to exceed the expectations of all generations of Americans if it approaches Social Security reform in a timely and reasonable manner. Unfortunately, I hate to say I do not think that is the case with Medicare. The expectation gap is so great, the situation is getting worse, that it is going to require heavy lifting on an incremental basis over an extended period of time.

Thank you, Mr. Chairman.

[The prepared statement of David M. Walker follows:]

PREPARED STATEMENT OF HON. DAVID M. WALKER, COMPTROLLER GENERAL OF THE UNITED STATES

Mr. Chairman and members of the committee, I am pleased to be here today as you discuss the long-term financial condition of the Medicare program. In previous congressional testimony over the past several years, I have consistently stressed that without meaningful reform, demographic and cost trends will drive Medicare spending to unsustainable levels.[1] These trends highlight the need to act now rather than later when needed changes will be increasingly more painful and disruptive.

Although the short-term outlook of Medicare's Hospital Insurance trust fund improved somewhat in the last year, the long-term projections are much worse due to a change in expectations about future health care costs. Specifically, the Medicare Trustees' latest projections released in March incorporate more realistic—i.e., higher—assumptions about long-term health care spending. As a result, the long-term outlook for Medicare's financial future—both Hospital Insurance (HI) and Supplementary Medical Insurance (SMI)—is considerably worse than previously estimated. The Congressional Budget Office (CBO) also increased its long-term estimates of Medicare spending. The slowdown in Medicare spending growth that we have seen in recent years appears to have come to an end. In the first 8 months of fiscal year 2001, Medicare spending was 7.5 percent higher than the previous year. The fiscal discipline imposed through the Balanced Budget Act of 1997 (BBA) continues to be challenged, while interest in modernizing the Medicare benefits package to include prescription drug coverage has increased. Taken together, these developments mean higher, not lower health care cost growth. They reinforce the need to begin taking steps to address the challenges of meaningful Medicare reform. In pursuing such reform, it is important to focus on the long-term sustainability of the combined Medicare program, rather than the solvency of the HI trust fund alone.

Ultimately, any comprehensive Medicare reform must confront several fundamental challenges. In summary:

- Medicare spending is likely to grow faster than previously estimated. The Medicare Trustees are now projecting that, in the long-term, Medicare costs will eventually grow at 1 percentage point above per-capita gross domestic product (GDP) each year—about 1 percentage point faster per year than the previous assumption. Accordingly, as estimated by the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS)—formerly known as the Health Care Financing Administration (HCFA), the estimated net present value of future additional resources needed to fund Part A HI benefits over the next 75 years increased from $2.6 trillion last year to $4.6 trillion this year—an increase of more than 75 percent.
- Our long-term budget simulations show that demographics and health care spending will drive us back into periods of escalating deficits and debt absent meaningful entitlement reforms or other significant tax or spending actions. Our March 2001 long-term simulations show that even if the often-stated goal of saving all Social Security surpluses is realized, large and persistent deficits will return in less than 20 years.
- Medicare's sustainability can no longer be measured merely using the traditional measure of HI trust fund solvency. The financial status of this trust fund does not reflect the whole picture. In fact, focusing on solvency can be misleading and give a false sense of security regarding the overall condition of the Medicare program. Both Part A expenditures financed through payroll taxes and Part B SMI expenditures financed through general revenues and beneficiary premiums must be taken into consideration. When viewed from this comprehensive perspective, total

Medicare spending is projected to double as a share of GDP by 2035. Importantly, this estimate does not include the cost of any prescription drug benefit.

• Since the cost of a drug benefit would boost these spending projections even further, adding prescription drug coverage will require difficult policy choices that will likely have significant effects on beneficiaries, taxpayers, and the program. Recognition of who bears the cost of Medicare is critical. Currently, there may not be full awareness that beneficiaries' payroll tax contributions and premiums generally finance considerably less than their lifetime benefits.

• Properly structured reforms to promote competition among health plans can help make beneficiaries more cost conscious. However, improvements to traditional fee-for-service (FFS) Medicare are also critical, as it will likely remain dominant for some time to come.

• Fiscal discipline is difficult, but the continued importance of traditional Medicare underscores the need to base adjustments to provider payments on hard evidence rather than anecdotal information and to carefully target relief where it is both needed and deserved.

• Similarly, reform of Medicare's management, which is on the table as discussions of Medicare program reforms proceed, will require carefully targeted efforts to ensure that adequate resources are appropriately coupled with improved performance and increased accountability.

• Ultimately, we will need to look at broader health care reforms to balance health care spending with other societal priorities. In doing this, it is important to look at the entire range of Federal policy tools—tax policy, spending, and regulation. It is also important to note the fundamental differences between health care wants, which are virtually unlimited, from needs, which should be defined and addressed, and overall affordability, of which there is a limit. In the end, we will need to take a range of steps to increase the transparency of health care costs and quality, target assistance to those in need, re-examine incentives, and assure accountability for desired outcomes.

The consensus that Medicare is likely to cost more than previously estimated serves to reinforce the need to act soon. Realistically, reforms to address the Medicare program's huge long-range financial imbalance will need to proceed incrementally. In addition, efforts to update the program's benefits package will need careful and cautious deliberation. As the Congress considers Medicare reform, it will be important to adopt effective cost containment reforms alongside potential benefit expansions. Any benefit expansion efforts will need to be coupled with adequate program reforms if Medicare's long-range financial condition is not to be worsened. This is especially important in connection with a potential prescription drug benefit, as this coverage represents the fastest-growing expenditure for many public and private health plans. Therefore, the time to begin these difficult, but necessary, incremental steps is now.

MEDICARE'S LONG-TERM FINANCIAL FUTURE LOOKS WORSE

As I have stated in other testimony, Medicare as currently structured is fiscally unsustainable. While many people have focused on the improvement in the HI trust fund's shorter-range solvency status, the real news is that we now have a more realistic view of Medicare's long-term financial condition and the outlook is much bleaker. A consensus has emerged that previous program spending projections have been based on overly optimistic assumptions and that actual spending will grow faster than has been assumed.

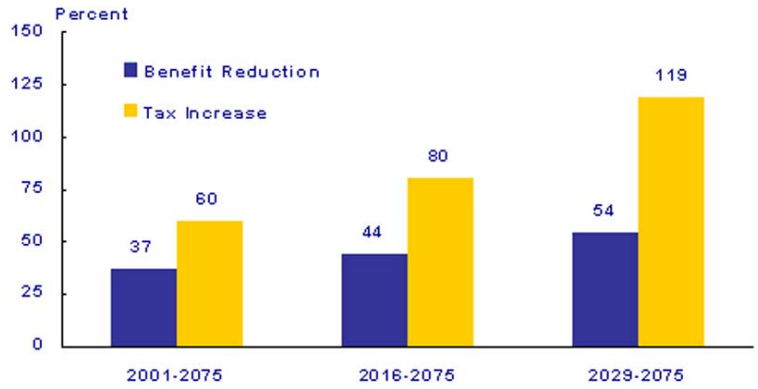
TRADITIONAL HI TRUST FUND SOLVENCY MEASURE IS A POOR INDICATOR OF MEDICARE'S FISCAL HEALTH

First, let me talk about how we measure Medicare's fiscal health. In the past, Medicare's financial status has generally been gauged by the projected solvency of the HI trust fund, which covers primarily inpatient hospital care and is financed by payroll taxes. Looked at this way, Medicare—more precisely, Medicare's Hospital Insurance trust fund—is described as solvent through 2029.

However, even from the perspective of HI trust fund solvency, the estimated exhaustion date of 2029 does not mean that we can or should wait until then to take action. In fact, delay in addressing the HI trust fund imbalance means that the actions needed will be larger and more disruptive. Taking action today to restore solvency to the HI trust fund for the next 75 years would require benefit cuts of 37 percent or tax increases of 60 percent, or some combination of the two. While these actions would not be easy or painless, postponing action until 2029 would require more than doubling of the payroll tax or cutting benefits by more than half to maintain solvency. (See fig. 1.) Given that in the long-term, Medicare cost growth is now

projected to grow at 1 percentage point faster than GDP, HI's financial condition is expected to continue to worsen after the 75-year period. By 2075, HI's annual financing shortfall—the difference between program income and benefit costs—will reach 7.35 percent of taxable payroll. This means that if no action is taken this year, shifting the 75-year horizon out 1 year to 2076—a large deficit year—and dropping 2001—a surplus year—would yield a higher actuarial deficit, all other things being equal.

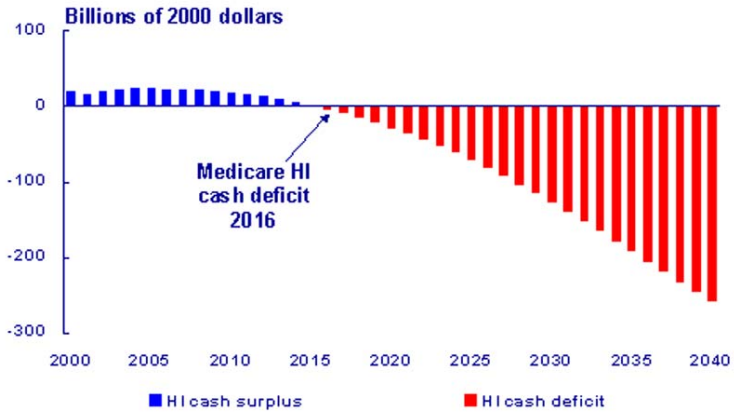
FIGURE 1: ESTIMATED BENEFIT REDUCTION OR TAX INCREASE NECESSARY TO RESTORE HI TRUST FUND SOLVENCY



Source: Office of the Actuary, CMS, 2001 intermediate assumptions.

Moreover, HI trust fund solvency does not mean the program is financially healthy. Under the Trustees' 2001 intermediate estimates, HI outlays are projected to exceed HI tax revenues beginning in 2016, the same year in which Social Security outlays are expected to exceed tax revenues. (See fig. 2.) As the baby boom generation retires and the Medicare-eligible population swells, the imbalance between outlays and revenues will increase dramatically. Thus, in 15 years the HI trust fund will begin to experience a growing annual cash deficit. At that point, the HI program must redeem Treasury securities acquired during years of cash surplus. Treasury, in turn, must obtain cash for those redeemed securities either through increased taxes, spending cuts, increased borrowing, retiring less debt, or some combination thereof.

FIGURE 2: MEDICARE'S HOSPITAL INSURANCE TRUST FUND FACES CASH DEFICITS AS BABY BOOMERS RETIRE



Source: GAO analysis of data from the Office of the Actuary, CMS, 2001 intermediate assumptions.

Finally, HI trust fund solvency does not measure the growing cost of the Part B SMI component of Medicare, which covers outpatient services and is financed through general revenues and beneficiary premiums.[2] Part B accounts for somewhat more than 40 percent of Medicare spending and is expected to account for a growing share of total program dollars. As the Trustees noted in this year's report, a rapidly growing share of general revenues and substantial increases in beneficiary premiums will be required to cover part B expenditures.

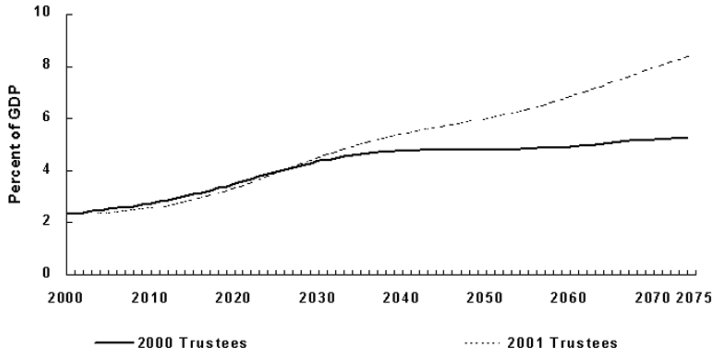
Clearly, it is total program spending—both Part A and Part B—relative to the entire Federal budget and national economy that matters. This total spending approach is a much more realistic way of looking at the combined Medicare program's sustainability. In contrast, the historical measure of HI trust fund solvency cannot tell us whether the program is sustainable over the long haul. Worse, it can serve to distort perceptions about the timing, scope, and magnitude of our Medicare challenge.

NEW ESTIMATES INCREASE URGENCY OF REFORM EFFORTS

These figures reflect a worsening of the long-term outlook. Last year a technical panel advising the Medicare Trustees recommended assuming that future per-beneficiary costs for both HI and SMI eventually will grow at a rate 1 percentage point above GDP growth—about 1 percentage point higher than had previously been assumed.[3] That recommendation—which was consistent with a similar change CBO had made to its Medicare and Medicaid long-term cost growth assumptions[4]—was adopted by the Trustees. In their new estimates published on March 19, 2001, the Trustees adopted the technical panel's long-term cost growth recommendation.[5] The Trustees note in their report that this new assumption substantially raises the long-term cost estimates for both HI and SMI. In their view, incorporating the technical panel's recommendation yields program spending estimates that represent a more realistic assessment of likely long-term program cost growth.

Under the old assumption (the Trustees' 2000 best estimate intermediate assumptions), total Medicare spending consumed 5 percent of GDP by 2063. Under the new assumption (the Trustees' 2001 best estimate intermediate assumptions), this occurs almost 30 years sooner in 2035—and by 2075 Medicare consumes over 8 percent of GDP, compared with 5.3 percent under the old assumption. The difference clearly demonstrates the dramatic implications of a 1-percentage point increase in annual Medicare spending over time. (See fig. 3)

FIGURE 3: MEDICARE SPENDING AS A SHARE OF GDP UNDER OLD AND NEW ASSUMPTIONS

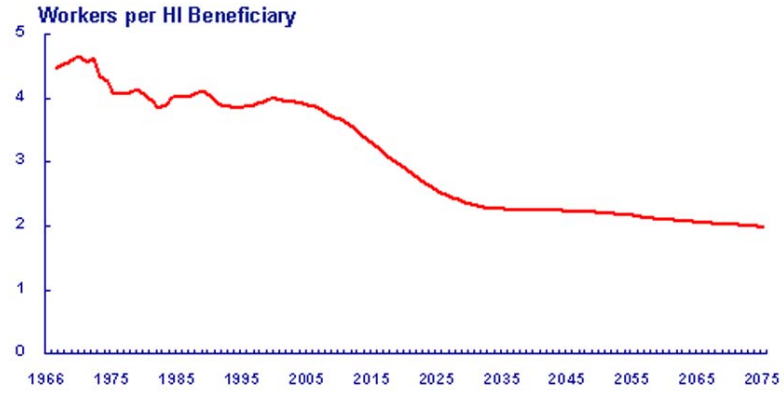


Note: Data are gross outlays as projected under the Trustees' intermediate assumptions.

Source: GAO analysis of data from the 2000 and 2001 HI and SMI Trustees Reports.

In part the progressive absorption of a greater share of the Nation's resources for health care, as with Social Security, is a reflection of the rising share of the population that is elderly. Both programs face demographic conditions that require action now to avoid burdening future generations with the program's rising costs. Like Social Security, Medicare's financial condition is directly affected by the relative size of the populations of covered workers and beneficiaries. Historically, this relationship has been favorable. In the near future, however, the covered worker-to-retiree ratio will change in ways that threaten the financial solvency and sustainability of this important national program. In 1970 there were 4.6 workers per HI beneficiary. Today there are about 4, and in 2030, this ratio will decline to only 2.3 workers per HI beneficiary.[6] (See fig. 4.)

FIGURE 4: WORKERS PER HI BENEFICIARY EXPECTED TO DECLINE



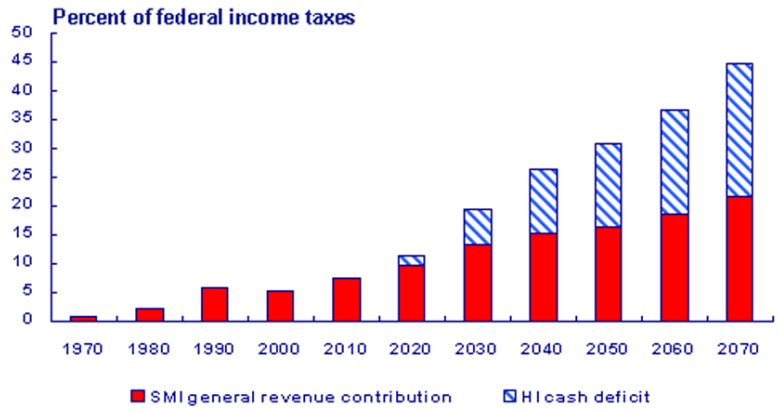
Source: GAO analysis of data from the Office of the Actuary, CMS.

Unlike Social Security, however, Medicare growth rates reflect not only a burgeoning beneficiary population, but also the escalation of health care costs at rates well

exceeding general rates of inflation. Increases in the number and quality of health care services have been fueled by the explosive growth of medical technology.[7] Moreover, the actual costs of health care consumption are not transparent. Third-party payers generally insulate consumers from the cost of health care decisions. All of these factors contribute to making Medicare a much greater and more complex fiscal challenge than even Social Security.

When viewed from the perspective of the Federal budget and the economy, the growth in health care spending will become increasingly unsustainable over the longer term.[8] Figure 5 shows the sum of the future expected HI cash deficit and the expected general fund contribution to SMI as a share of Federal income taxes under the Trustees 2001 intermediate estimates. SMI has received contributions from the general fund since the inception of the program. This general revenue contribution is projected to grow from about 5 percent of Federal personal and corporate income taxes in 2000 to 13 percent by 2030. Beginning in 2016, use of general fund revenues will be required to pay benefits as the HI trust fund redeems its Treasury securities. Assuming general fund revenues are used to pay benefits after the trust fund is exhausted, by 2030 the HI program alone would consume more than 6 percent of income tax revenue. On a combined basis, Medicare's draw on general revenues would grow from 5.4 percent of income taxes today to nearly 20 percent in 2030 and 45 percent by 2070.

FIGURE 5: SMI GENERAL REVENUE CONTRIBUTION AND HI CASH DEFICIT AS A SHARE OF FEDERAL CORPORATE AND PERSONAL INCOME TAXES



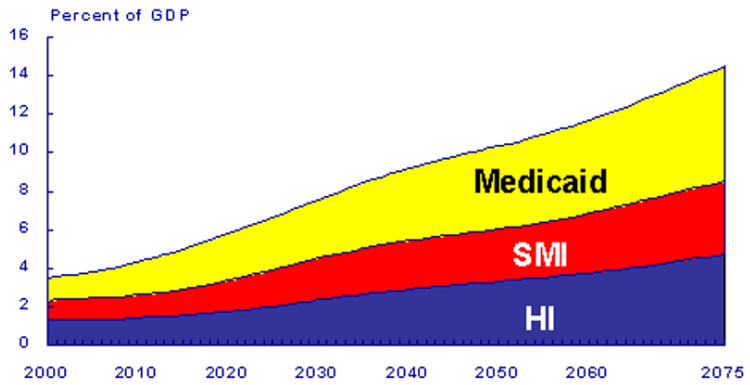
Note: Estimates are based on the Trustees' 2001 intermediate assumptions and assume that personal and corporate Federal income taxes remain at the same share of gross domestic product as in 2000.

Source: GAO analysis of data from the Office of the Chief Actuary, CMS, 2001 intermediate assumptions.

Figure 6 reinforces the need to look beyond the HI program. HI is only the first layer in this figure. The middle layer adds the SMI program, which is expected to grow faster than HI in the near future. By the end of the 75-year projection period, SMI will represent almost half of total estimated Medicare costs.

To get a more complete picture of the future Federal health care entitlement burden, Medicaid is added. Medicare and the Federal portion of Medicaid together will grow to 14.5 percent of GDP from today's 3.5 percent. Taken together, the two major government health programs—Medicare and Medicaid—represent an unsustainable burden on future generations. In addition, this figure does not reflect the taxpayer burden of state and local Medicaid expenditures. A recent statement by the National Governors Association argues that increased Medicaid spending has already made it difficult for states to increase funding for other priorities.

FIGURE 6: MEDICARE AND MEDICAID SPENDING AS A SHARE OF GDP



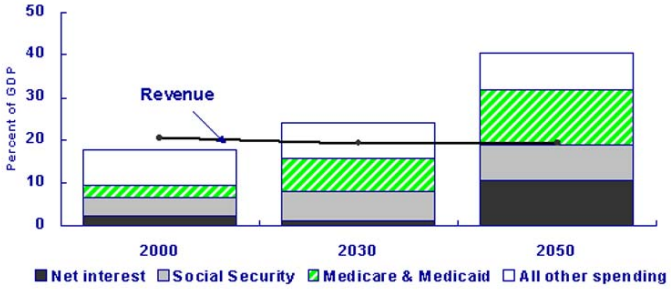
Notes:

1. Medicare data are gross outlays as projected under the Trustees' 2001 intermediate assumptions.
2. Federal Medicaid data based on CBO's October 2000 long-term budget outlook.

Source: GAO analysis of data from the Congressional Budget Office and the March 2001 HI and SMI Trustees Reports.

Our long-term simulations show that to move into the future with no changes in Federal health and retirement programs is to envision a very different role for the Federal Government. Assuming, for example, that Congress and the President adhere to the often-stated goal of saving the Social Security surpluses, our long-term simulations show a world by 2030 in which Social Security, Medicare, and Medicaid absorb most of the available revenues within the Federal budget. Under this scenario, these programs would require more than three-quarters of total Federal revenue even without adding a Medicare prescription drug benefit. (See fig. 7.)

FIGURE 7: COMPOSITION OF FEDERAL SPENDING AS A SHARE OF GDP UNDER THE "SAVE THE SOCIAL SECURITY SURPLUSES" SIMULATION



Notes:

1. Revenue as a share of GDP declines from its 2000 level of 20.6 percent due to unspecified permanent policy actions. In this display, policy changes are allocated equally between revenue reductions and spending increases.
2. The "Save the Social Security Surpluses" simulation can only be run through 2056 due to the elimination of the capital stock.

Source: GAO's March 2001 analysis.

This scenario contemplates saving surpluses for 20 years—an unprecedented period of surpluses in our history—and retiring publicly held debt. Alone, however,

even saving all Social Security surpluses would not be enough to avoid encumbering the budget with unsustainable costs from these entitlement programs. Little room would be left for other Federal spending priorities such as national defense, education, and law enforcement. Absent changes in the structure of Medicare and Social Security, sometime during the 2040's government would do nothing but mail checks to the elderly and their health care providers. Accordingly, substantive reform of the Medicare and Social Security programs remains critical to recapturing our future fiscal flexibility.

Demographics argue for early action to address Medicare's fiscal imbalances. Ample time is required to phase in the reforms needed to put this program on a more sustainable footing before the baby boomers retire. In addition, timely action to bring costs down pays large fiscal dividends for the program and the budget. The high projected growth of Medicare in the coming years means that the earlier reform begins, the greater the savings will be as a result of the effects of compounding.

Beyond reforming the Medicare program itself, maintaining an overall sustainable fiscal policy and strong economy is vital to enhancing our Nation's future capacity to afford paying benefits in the face of an aging society. Today's decisions can have wide-ranging effects on our ability to afford tomorrow's commitments. As I have testified before, you can think of the budget choices you face as a portfolio of fiscal options balancing today's unmet needs with tomorrow's fiscal challenges. At the one end—with the lowest risk to the long-range fiscal position—is reducing publicly held debt. At the other end—offering the greatest risk—is increasing entitlement spending without fundamental program reform.

Reducing publicly held debt helps lift future fiscal burdens by freeing up budgetary resources encumbered for interest payments, which currently represent about 12 cents of every Federal dollar spent, and by enhancing the pool of economic resources available for private investment and long-term economic growth. This is particularly crucial in view of the known fiscal pressures that will begin bearing down on future budgets in about 10 years as the baby boomers start to retire. However, as noted above, debt reduction is not enough. Our long-term simulations illustrate that, absent entitlement reform, large and persistent deficits will return.

MEDICARE'S BLEAK FINANCIAL OUTLOOK DRIVES NEED FOR MEANINGFUL PROGRAM AND MANAGEMENT REFORM

Despite common agreement that, without reform, future program costs will consume growing shares of the Federal budget, there is also a mounting consensus that Medicare's benefit package should be expanded to cover prescription drugs, which will add billions to the program's cost. This places added pressure on policymakers to consider proposals that could fundamentally reform Medicare. Our previous work provides, I believe, some considerations that are relevant to deliberations regarding the potential addition of a prescription drug benefit and Medicare reform options that would inject competitive mechanisms to help control costs. In addition, our reviews of HCFA offer lessons for improving Medicare's management. Implementing necessary reforms that address Medicare's financial imbalance and meet the needs of beneficiaries will not be easy. We must have a Medicare agency that is ready and able to meet these 21st century challenges.

ADDING A FISCALLY RESPONSIBLE PRESCRIPTION DRUG BENEFIT WILL ENTAIL MULTIPLE TRADE-OFFS

Among the major policy challenges facing the Congress today is how to reconcile Medicare's unsustainable long-range financial condition with the growing demand for an expensive new benefit—namely, coverage for prescription drugs. It is a given that prescription drugs play a far greater role in health care now than when Medicare was created. Today, Medicare beneficiaries tend to need and use more drugs than other Americans. However, because adding a benefit of such potential magnitude could further erode the program's already unsustainable financial condition, you face difficult choices about design and implementation options that will have a significant impact on beneficiaries, the program, and the marketplace.

Let's examine the current status regarding Medicare beneficiaries and drug coverage. About a third of Medicare beneficiaries have no coverage for prescription drugs. Some beneficiaries with the lowest incomes receive coverage through Medicaid. Some beneficiaries receive drug coverage through former employers, some can join Medicare+Choice plans that offer drug benefits, and some have supplemental Medigap coverage that pays for drugs. However, significant gaps remain. For example, Medicare+Choice plans offering drug benefits are not available everywhere and generally do not provide catastrophic coverage. Medigap plans are expensive and

have caps that significantly constrain the protection they offer. Thus, beneficiaries with modest incomes and high drug expenditures are most vulnerable to these coverage gaps.

Overall, the Nation's spending on prescription drugs has been increasing about twice as fast as spending on other health care services, and it is expected to keep growing. Recent estimates show that national per-person spending for prescription drugs will increase at an average annual rate exceeding 10 percent until at least 2010. As the cost of drug coverage has been increasing, employers and Medicare+Choice plans have been cutting back on prescription drug benefits by raising enrollees' cost-sharing, charging higher co-payments for more expensive drugs, or eliminating the benefit altogether.

It is not news that adding a prescription drug benefit to Medicare will be costly. However, the cost consequences of a Medicare drug benefit will depend on choices made about its design—including the benefit's scope and financing mechanism. For instance, a Medicare prescription drug benefit could be designed to provide coverage for all beneficiaries, coverage only for beneficiaries with extraordinary drug expenses, coverage only for low-income beneficiaries. Policy makers would need to determine how costs would be shared between taxpayers and beneficiaries through premiums, deductibles, and co-payments and whether subsidies would be available to low-income, non-Medicaid eligible individuals. Design decisions would also affect the extent to which a new pharmaceutical benefit might shift to Medicare portions of the out-of-pocket costs now borne by beneficiaries as well as those costs now paid by Medicaid, Medigap, or employer plans covering prescription drugs for retirees. Clearly, the details of a prescription drug benefit's implementation would have a significant impact on both beneficiaries and program spending. Experience suggests that some combination of enhanced access to discounted prices, targeted subsidies, and measures to make beneficiaries more aware of costs may be needed. Any option would need to balance concerns about Medicare sustainability with the need to address what will likely be a growing hardship for some beneficiaries in obtaining prescription drugs.

REFORM OPTIONS BASED ON COMPETITION OFFER ADVANTAGES BUT CONTAIN LIMITATIONS

The financial prognosis for Medicare clearly calls for meaningful spending reforms to help ensure that the program is sustainable over the long haul. The importance of such reforms will be heightened if financial pressures on Medicare are increased by the addition of new benefits, such as coverage for prescription drugs. Some leading reform proposals envision that Medicare could achieve savings by adapting some of the competitive elements embodied in the Federal Employees Health Benefits Program. Specifically, these proposals would move Medicare toward a model in which health plans compete on the basis of benefits offered and costs to the government and beneficiaries, making the price of health care more transparent.

Currently, Medicare follows a complex formula to set payment rates for Medicare+Choice plans, and plans compete primarily on the richness of their benefit packages. Medicare permits plans to earn a reasonable profit, equal to the amount they can earn from a commercial contract. Efficient plans that keep costs below the fixed payment amount can use the "savings" to enhance their benefit packages, thus attracting additional members and gaining market share. Under this arrangement, competition among Medicare plans may produce advantages for beneficiaries, but the government reaps no savings.[9]

In contrast, a competitive premium approach offers certain advantages. Instead of having the government administratively set a payment amount and letting plans decide—subject to some minimum requirements—the benefits they will offer, plans would set their own premiums and offer at least a required minimum Medicare benefit package. Under these proposals, Medicare costs would be more transparent: beneficiaries could better see what they and the government were paying for in connection with health care expenditures. Beneficiaries would generally pay a portion of the premium and Medicare would pay the rest. Plans operating at lower cost could reduce premiums, attract beneficiaries, and increase market share. Beneficiaries who joined these plans would enjoy lower out-of-pocket expenses. Unlike today's Medicare+Choice program, the competitive premium approach provides the potential for taxpayers to benefit from the competitive forces. As beneficiaries migrated to lower-cost plans, the average government payment would fall.

Experience with the Medicare+Choice program reminds us that competition in Medicare has its limits. First, not all geographic areas are able to support multiple health plans. Medicare health plans historically have had difficulty operating efficiently in rural areas because of a sparseness of both beneficiaries and providers.

In 2000, 21 percent of rural beneficiaries had access to a Medicare+Choice plan, compared to 97 percent of urban beneficiaries. Second, separating winners from losers is a basic function of competition. Thus, under a competitive premium approach, not all plans would thrive, requiring that provisions be made to protect beneficiaries enrolled in less successful plans.

EFFECTIVE PROGRAM MANAGEMENT KEY TO SUCCESSFUL REFORM EFFORTS

The extraordinary challenge of developing and implementing Medicare reforms should not be underestimated. Our look at health care spending projections shows that, with respect to Medicare reform, small implementation problems can have huge consequences. To be effective, a good program design will need to be coupled with competent program management. Consistent with that view, questions are being raised about the ability of CMS to administer the Medicare program effectively.

Our reviews of Medicare program activities confirm the legitimacy of these concerns. In our companion statement today, we discuss not only the Medicare agency's performance record but also areas where constraints have limited the agency's achievements. We also identify challenges the agency faces in seeking to meet expectations for the future.

As the Congress and the administration focus on current Medicare management issues, our review of HCFA suggests several lessons:

• Managing for results is fundamental to an agency's ability to set meaningful goals for performance, measure performance against those goals, and hold managers accountable for their results. Our work shows that HCFA has faltered in adopting a results-based approach to agency management, leaving the agency in a weakened position for assuming upcoming responsibilities. In some instances, the agency may not have the tools it needs because it has not been given explicit statutory authority. For example, the agency has sought explicit statutory authority to use full and open competition to select claims administration contractors. The agency believes that without such statutory authority it is at a disadvantage in selecting the best performers to carry out Medicare claims administration and customer service functions. To be effective, any agency must be equipped with the full complement of management tools it needs to get the job done.

• A high-performance organization demands a workforce with, among other things, up-to-date skills to enhance the agency's value to its customers and ensure that it is equipped to achieve its mission. HCFA began workforce planning efforts that continue today in an effort to identify areas in which staff skills are not well matched to the agency's evolving mission. In addition, CMS recently reorganized its structure to be more responsive to its customers. It is important that CMS continue to reevaluate its skill needs and organizational structure as new demands are placed on the agency.

• Data-driven information is essential to assess the budgetary impact of policy changes and distinguish between desirable and undesirable consequences. Ideally, the agency that runs Medicare should have the ability to monitor the effects of Medicare reforms, if enacted—such as adding a drug benefit or reshaping the program's design. However, HCFA was unable to make timely assessments, largely because its information systems were not up to the task. The status of these systems remains the same, leaving CMS unprepared to determine, within reasonable time frames, the appropriateness of services provided and program expenditures. The need for timely, accurate, and useful information is particularly important in a program where small rate changes developed from faulty estimates can mean billions of dollars in overpayments or underpayments.

• An agency's capacity should be commensurate with its responsibilities. As the Congress continues to modify Medicare, CMS' responsibilities will grow substantially. HCFA's tasks increased enormously with the enactment of landmark Medicare legislation in 1997 and the modifications to that legislation in 1999 and 2000. In addition to the growth in Medicare responsibilities, the agency that administers this program is also responsible for other large health insurance programs and activities. As the agency's mission has grown, however, its administrative dollars have been stretched thinner. Adequate resources are vital to support the kind of oversight and stewardship activities that Americans have come to count on—inspection of nursing homes and laboratories, certification of Medicare providers, collection and analysis of critical health care data, to name a few. Shortchanging this agency's administrative budget will put the agency's ability to handle upcoming reforms at serious risk.

In short, because Medicare's future will play such a significant role in the future of the American economy, we cannot afford to settle for anything less than a world-

class organization to run the program. However, achieving such a goal will require a clear recognition of the fundamental importance of efficient and effective day-to-day operations.

CONCLUSIONS

In determining how to reform the Medicare program, much is at stake-not only the future of Medicare itself but also assuring the Nation's future fiscal flexibility to pursue other important national goals and programs. I feel that the greatest risk lies in doing nothing to improve the Medicare program's long-term sustainability. It is my hope that we will think about the unprecedented challenge facing future generations in our aging society. Engaging in a comprehensive effort to reform the Medicare program and put it on a sustainable path for the future would help fulfill this generation's stewardship responsibility to succeeding generations. It would also help to preserve some capacity for future generations to make their own choices for what role they want the Federal Government to play.

Updating Medicare's benefit package may be a necessary part of any realistic reform program. Such changes, however, need to be considered in the context of Medicare's long-term fiscal outlook and the need to make changes in ways that will promote the program's longer-term sustainability. We must remember that benefit expansions are often permanent, while the more belt-tightening payment reforms—vulnerable to erosion—could be discarded altogether. The BBA experience reminds us about the difficulty of undertaking reform.

Most importantly, any substantial benefit reform should be coupled with other meaningful program reforms that will help to ensure the long-term sustainability of the program. In the end, the Congress should consider adopting a Hippocratic oath for Medicare reform proposals—namely, "Don't make the long-term outlook worse." Ultimately, we will need to engage in a much more fundamental health care reform debate to differentiate wants, which are virtually unlimited, from needs, which should be defined and addressed, and overall affordability, of which there is a limit.

We at GAO look forward to continuing to work with this Committee and the Congress in addressing this and other important issues facing our Nation. In doing so, we will be true to our core values of accountability, integrity, and reliability.

Chairman Nussle, this concludes my prepared statement. I will be happy to answer any questions you or other Members of the Committee may have.

ENDNOTES

1 Medicare: Higher Expected Spending and Call for New Benefit Underscore Need for Meaningful Reform (GAO-01-539T, March 22, 2001); Medicare Reform: Leading Proposals Lay Groundwork, While Design Decisions Lie Ahead (GAO/T-HEHS-AIMD-00-103, Feb. 24, 2000); Medicare Reform: Ensuring Fiscal Sustainability While Modernizing the Program Will Be Challenging (GAO/T-HEHS/AIMD-99-294, Sept. 22, 1999).

2. At Medicare's inception, the law initially established a formula for Part B premiums that set the rate to cover 50 percent of expected program costs for aged enrollees, with the remaining 50 percent covered by general revenues. Legislation enacted in 1972 limited the annual percentage increase in the premium to the same percentage by which Social Security benefits were adjusted for changes in cost of living. As a result, from the mid-1970's through the early 1980's, the portion of program costs covered by premium income dropped from 50 percent to below 25 percent. Beginning in the early 1980's, Congress regularly voted to set part B premiums at a level to cover 25 percent of expected program costs, in effect overriding the cost-of-living adjustment limitation. In 1997 BBA permanently set the rate at 25 percent.

3. Technical Review Panel on the Medicare Trustees Reports, Review of Assumptions and Methods of the Medicare Trustees' Financial Projections (Dec. 2000). As the panel noted, for many years the Medicare projections have been based on an assumption that in the long run, average per-beneficiary costs would increase at about the same rate as program underlying funding sources. For HI, this meant that expenditures were assumed to increase at the same rate as average hourly earnings. For SMI, this meant that per-beneficiary costs were assumed to grow at the same rate as per-capita GDP.

4. CBO, The Long-Term Budget Outlook (Oct. 2000).

5. See 2001 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund (March 2001) and 2001 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund (March 2001).

6. For Social Security, there were 3.7 covered workers per beneficiary in 1970. Today there are 3.4, and the ratio is expected to decline to 2.1 in 2030.

7. In arriving at their recommendation for Medicare long-term cost growth, the Medicare Technical Panel observed that historically, the primary long-run determinant of real health care spending has been the development and diffusion of new medical technology.

8. See Long-Term Budget Issues: Moving from Balancing the Budget to Balancing Fiscal Risk (GAO-01-385T, Feb. 6, 2001).

9. In fact, the government has been losing money on the Medicare+Choice program. Medicare pays more, on average, for beneficiaries enrolled in managed care plans than if these individuals had remained in traditional Medicare. See Medicare+Choice: Payments Exceed Cost of Fee-for-Service Benefits, Adding Billions to Spending (GAO/HEHS-00-161, Aug. 23, 2000).

Chairman NUSSLE. Thank you, Mr. Walker.

First of all, I want to make sure I am clear on your medicine, or what you are suggesting that we should do. I do not want you to leave the impression that the only two alternatives are to cut benefits or raise taxes. What I hear you saying is, that may be the only solution that is left if we do not act now. Is that what you are suggesting?

Mr. WALKER. That is correct. I mean, obviously, to the extent that you can increase economic growth further, then that ends up increasing the pie and therefore the relevant burden becomes less. Although I would point out that in the projections that we have, the first one—what I call the hair cut chart or the scalp chart—it assumes very healthy productivity growth. It assumes a paradigm shift in the economy, that we are now in a knowledge-based economy, and where we are going to be be able to sustain a lot higher annual productivity rates than historically has been the case.

Chairman NUSSLE. But it also assumes the status quo with Medicare; that the program does not change.

Mr. WALKER. It assumes the status quo with Medicare and Social Security and that Congress spends the on-budget surplus but saves every penny of the Social Security surplus. But unfortunately as you know, Mr. Chairman, the Social Security system will not have a surplus starting in 2016. It will still have a trust fund with significant assets in it, but it will not have a cash flow surplus and therefore this represents a period of significant challenge.

Chairman NUSSLE. Now, the alarm that you are sending is a big one. And it is deafening and serious, and I take it that way. And yet in your testimony, both written and oral today, you indicate that the change should be incremental. And I am just wondering what you mean by incremental. When you say "incremental," what are you suggesting? Because what I hear you saying is act big and act now; but "incremental" suggests a little something different than that.

Mr. WALKER. I am trying to be realistic, Mr. Chairman. I think there is clearly a need to act sooner rather than later. I think that there is a need for fundamental reform. At the same point in time, the gap between promised benefits and funded benefits is so great I believe it is unrealistic to expect that you are going to be able to address that in one fell swoop. The gap is just too great.

The other thing I think we have to understand, and I am sure you and the other members appreciate that the further out you go, the more uncertainty there is. So therefore, you may not want to

try to address everything all at once, until you get a little bit closer, to find out are things as bad as they appear to be, are they better or are they worse?

But what we do know for sure is that this is driven by two factors, known demographic trends which are a lot more reliable than certain other trends, because the people are alive; and secondly, rising health care costs which appear to be back and appear to be back with vigor.

Chairman NUSSLE. We heard testimony at the last hearing with regard to budget reform that there is somewhere near 200 different trust funds in the government and that just about every one has a different definition. What we discovered is that if Congress calls it a trust fund, it is a trust fund. Yet when I think of the word "trust fund," I think of something a little bit more secure and much more trustworthy than maybe just calling it a trust fund. What is the trust fund? Tell us what the Medicare Trust Fund—is that we are all referring to. Exactly what is it and how does it work?

Mr. WALKER. There are actually two Medicare Trust Funds. There is the Part A Trust Fund, which is HI, which is depicted on the other chart that I showed, the cash flows for HI. And there is the Part B Trust Fund, which is SMI. Part A is financed through payroll taxes primarily. Part B is financed about 25 percent through beneficiary premiums, and about 75 percent through general revenues.

The trust fund is largely an accounting device. It is a means by which you can keep track of annual revenues and annual expenses. To the extent that there are surpluses, which we are currently experiencing and have for the past several years, then it is a means by which you can keep account of the Federal Government's obligation to pay benefits and expenses of Medicare to the extent of those accumulated past surpluses.

As you know, by law, the government has to invest any surplus in securities that are backed by the full faith and credit of the United States Government. That is what is in these trust funds. But ultimately, in order to pay benefits when due, those securities must be converted into cash. To do that, you either are going to have to raise taxes, cut benefits, borrow from the public or do a combination thereof. So the trust funds are largely an accounting device in order to account for the government's obligations associated with these important programs.

Chairman NUSSLE. My final question is, because my time has expired—you amplify this in your testimony and again today orally—that you seem to be much more focused on the financial stability of Medicare versus the solvency of the trust funds. And yet in my tenure here in Congress, it sure seems like we focus on the solvency of the trust funds. That is where we always look for the solvency report from the Medicare trustees. We are constantly worried about how solvent this is out into the future.

And you are telling us today that is not the ball we ought to be keeping our eye on. It is financial stability. Would you explain what you mean by that and what we need to be watching?

Mr. WALKER. As you know, Mr. Chairman, I was a public trustee for Social Security/Medicare from 1990 to 1995, so I had to deal with this on the front line, if you will. Solvency does have some sig-

nificance, and so it is not that it is not significant; however, it is not the most significant issue. The real significance is, can the Federal Government deliver on the promises it has made to the current and future generations associated with the Medicare program and other programs.

To assess that, solvency is not the key measure. The key measure is sustainability, sustainability being focused on things like what percentage of the budget does the program represent; what percentage of the economy does the program represent; what are the consequences of the continued growth in this and other mandatory spending programs on the ability of the Congress to meet other discretionary spending needs or on the willingness and ability of the Congress to raise taxes to continue to fund these programs. And so the real key is what is the ability of the government to deliver on its promises, both now and in the future, and for that, sustainability is the key measure, not solvency.

Let me give you an example, because I think this is very important. If Medicare runs a surplus this year—HI—which it will, as we all know, then Congress by law will have to take whatever that amount of that annual surplus is and invest it in securities that are backed by the full faith and credit of the United States Government. Right now it is special issue securities that meet that definition, that bear interest and are guaranteed both as to principal and interest by the U.S. Government. But then Congress will take that cash and decide what to do with it.

The fact is, irrespective of what Congress does with that cash, cut taxes, increase spending, pay down debt, the solvency of the HI Trust Fund is exactly the same. It is not different by 1 penny. However, what the Congress decides to do with that money makes a big difference from a sustainability standpoint on the ability of the Congress to be able to deliver on its promises in the future and for this program to deliver.

All the more reason why solvency is not the key measure. Solvency does not deal with economics. Solvency really deals with a legal, moral and political obligation. It does not deal with economic substance. Sustainability deals with economic substance.

Chairman NUSSLE. Congress in its budget has decided that we are going to pay down debt with that cash. That was our commitment last year; that is our commitment this year. Is that what you would suggest is the best in the long term sustainability at least to start with without any reforms?

Mr. WALKER. Clearly the best thing for the long term is to take the surplus and pay down debt held by the public, because then you know you have accomplished something. Then you know you have relieved burdens in the future, which gives you additional flexibility and capacity to address those challenges when they come up.

Chairman NUSSLE. Thank you.

Mr. Spratt.

Mr. SPRATT. Let me follow up on that then. What you are saying is paying down outstanding debt, buying that debt up, redeeming it and putting it in the Part A Trust Fund is better than using the Part A Trust Fund to fund new benefits in Medicare, including pre-

scription drugs, when it comes to long term sustainability—your standard?

Mr. WALKER. Ultimately, Mr. Spratt, as you know, the Congress has to make these difficult decisions. From the long term sustainability standpoint, from the long term fiscal pressures, it is clearly less risk. It is clearly a preferred option to pay down debt held by the public. The least risk is to pay down debt held by the public. The highest risk is to increase entitlement spending.

Now if you decide, for example, to add a prescription drug benefit, then hopefully if you do that, that can be coupled with some program reforms that save money. Hopefully you will be in a situation where at least you don't make the situation worse. One of the things I say on the last page of my statement is that hopefully there can be a Medicare Hippocratic Oath, which means if you're going to add something, engage in reforms such that in the end you are at least not making the long term situation worse.

If you take Part A alone, $4.6 trillion is how much money we would have to have right now and invest it in order to be able to close the gap between promised and funded benefits just based upon the current situation, and that is without prescription drugs, and that is without SMI.

Mr. SPRATT. Does that assume that Medicare health care cost will grow at 1 percent above the rate of GDP growth?

Mr. WALKER. That is correct. It assumes that the most recent estimate that the Social Security/Medicare trustees came up with is the case. As you know, a 1 percent difference can make a huge difference because of compounding over time. For example, that 1 percent change drove the deficit, the unfunded liability, from $2.6 trillion to $4.6 trillion. Is it right? Candidly, God only knows, and God is not telling us. But what we do know, costs are on the rise again. And we do know that we have a system that doesn't provide adequate incentives, transparency or accountability to control cost, and therefore, we are going to have to end up doing something about that.

Mr. SPRATT. We are only 2 years removed from the year when we had a phenomenal result in Medicare; namely, no cost growth at all. What happened that year, and why is this year and the apparent future different?

Mr. WALKER. Well, one, there were a number of things that happened, one of which was BBA. BBA was an act which served to end up placing a significant constraint on reimbursements and cost control growth. A lot of BBA has been relieved, in some cases justifiably, because maybe there were unintended consequences. But in some cases relief may have been provided that may not have been justifiable.

The fact is, the private sector is seeing that health care costs are back on the rise, partially driven by prescription drugs. That is the fastest growing cost in the health care sector; partially driven by the fact that the benefits of managed care, which were gained by the private sector and, to a certain extent, the public sector over in the 1990's have played out. And so those are some of the reasons.

Mr. SPRATT. You stated earlier in your testimony that if and when we make reforms, we should base them upon hard evidence

and not anecdotal evidence. Do you have something particularly in mind where we went off on anecdotal evidence and were mistaken and did the wrong thing?

Mr. WALKER. I would suggest you ask Mr. Scanlon, who is head of our health care team, and they have done a tremendous amount of good work in this area, and I wouldn't want to steal his thunder.

Mr. SPRATT. Thank you very much.

Chairman NUSSLE. Mr. Gutknecht.

Mr. GUTKNECHT. I appreciate this testimony today, and it was a great life insurance salesman to demonstrate how much it was important to buy your life insurance when you were still young; used to carry around with him a marble, a golf ball and a baseball. He said, if you buy this insurance today, it is like carrying this marble around all the time. If you wait 5 years, it is going to be like carrying the next size ball up the list, and at some point it becomes so big that you can't get it in your pocket. I think that is where we are with this issue.

You have answered most of the questions I had. I am not really clear—I think you used the term "sustainability." Can you talk about that, what exactly you mean by that and why that is important?

Mr. WALKER. Sustainability is really, as I mentioned, focusing on the ability of the government to deliver on its promises. And if you look at sustainability, I think it is more important to look at the combined Medicare program, both Part A, Part B. If the Congress decides to pass prescription drugs, then whatever that might be as well, and what percentage of the Federal budget is represented by these combined programs; what percentage of the U.S. economy is represented by these combined programs; and what is the long term fiscal effect, in light of the ability of the Government to be able to fund other discretionary spending and the ability and willingness of the Congress and the American people to allow themselves to be taxed at higher levels.

I mean, this chart shows a lot. It says that if you continue the status quo, you are facing a future where you are going to have to significantly increase taxes, cut spending, or some combination thereof, by magnitudes that we have not experienced previously.

Mr. GUTKNECHT. Thank you, Mr. Chairman. I have no further questions.

Chairman NUSSLE. Mr. Bentsen.

Mr. BENTSEN. Thank you, Mr. Chairman.

Mr. Walker, a couple of things. You point out that the rising obligation and the sustainability of the program, and you talk about it in the context of the government's ability to fund this program. At what percentage of GDP do we think is enough or too much? Shouldn't this argument also be put into the context of society, because whether it was the government or private sector, health care costs and particularly health care costs for the elderly, are going to rise if there was no Medicare program. If we were to look at how much was being spent of GDP, it would rise proportional to the demographic changes that are going on in the country. So it seems to me we ought to put that in some perspective.

You made a point regarding as we go up the curve, what we do with the surplus. I appreciate your comment about the full faith

and credit, because there has been some confusion over the last week about whether or not those bonds are any good or not, and I think your point is well taken. I think if you read the bond, it is pretty clear in there.

But you said that the best approach would be to pay down debt. Now, the budget that passed the Congress allocates some to debt repayment and allocates some to tax cuts, but it also says we are going to spend $300 billion over the next 10 years out of the Medicare Trust Fund for the creation of a new prescription drug program. Now, I think, most of us are in favor of a drug prescription program, but the question I would ask you, is that not going in sort of the opposite direction, because aren't we, in effect, borrowing additionally against the trust fund or adding another $300 billion in long term obligation when we take those surplus receipts and use them to expand benefits under the program?

Mr. WALKER. That will have an adverse effect on solvency and sustainability. That will end up increasing the unfunded obligation of the Medicare program substantially.

Mr. BENTSEN. So that money probably runs at about—well, today it would be about 590 percent over a 30-year period that we are going to have to pay on that $300 billion, and maybe higher, depending on what the cost of debt is at the time.

In the privatization issue, you talk about the long term cost and the need for program reform. You also talk about—and I think very appropriately—that the managed care aspect of savings has somewhat played itself out. This has been true in Texas and across the Nation where we have seen the managed care companies getting out of the Medicare business because they can't make any money at it, and their costs are rising too rapidly. Part of that is due to prescription drug costs. And Congress has bumped up payment under the AAPCC to these companies.

Two questions. One is how close are we to the Federal Government paying a third party for the same benefit that can be provided directly through the Center of Medicare and Medicaid Services? The second question is, we hear a lot of talk about privatization or reform of the system in giving more choice and all these things, and trying to model after the private sector insurance or the Federal Employees Health Benefit Programs. All these things sound nice on their face, but I am worried about when you unwrap the package and look what it is inside. What are we talking about? Do we need to raise premiums dramatically on beneficiaries? Are we talking about having to curtail services, because as you say, just going to managed care, apparently—the empirical evidence has shown us that that is not going to provide savings, if any, certainly none close to what is necessary to get to long term sustainability. So what are we talking about?

Mr. WALKER. Let me address a couple of things. And I would suggest on some of the details of the Medicare program, Mr. Scanlon might be able to address that if I do not adequately respond.

First, let me take Medicare+Choice as an example. Medicare+Choice does not save the Federal Government money. It costs the Federal Government money. One of the reasons we put that in place was to save money. It is not saving money. It is costing money.

Secondly, if you look at the imbalances that exist, I think ultimately what the Congress is going to have to address is some fairly fundamental questions: What do people need versus what people want, versus what we can collectively afford? Needs have not been adequately defined, in my opinion, in health care. Wants are unlimited in health care. Everybody wants as much as they can get as long as somebody else is paying for it. And the collective affordability challenge is demonstrated by our long-range simulation.

I think ultimately Congress is going to have to get into tough issues like what is the nature of the promise; what are we promising under this program. For example, there are several different elements of health care, and as you know, I was a partner with Arthur Andersen for a number of years and did consulting in a number of areas including health care, pensions and a variety of other areas. One of the fundamental elements you have to have is the ability to purchase health care at group rates. In other words, guaranteed insurability at reasonable group rates. Secondly, protection against financial ruin due to an unexpected catastrophic illness. By the way, we do not have either one of those in this country, although we spend a lot of money on health care.

There is a difference between guaranteed access at group rates, leveraging purchase power, which government should do to help everybody, and who should pay for the coverage; and there is a difference between having a one-size-fits-all, which all too frequently we tend to do by saying this is the level of coverage. Everybody is going to get the same thing no matter what it costs, no matter what their means are and no matter what their needs are. Our current system is such that we have not separated between access to health care group rates, guaranteed insurability, protection in areas where people really need protection, and then targeting assistance to those who are truly in need, and that is part of the problem. The failure to do so is one of the reasons why health care costs are out of control.

If you look at our tax system, you can say our tax system is not exactly encouraging people to control health care costs, because the employer gets a deduction, which arguably they should because otherwise they pay it in wages, and they will get a deduction for, and obviously you want health care coverage. Individuals do not include in income the value of any of the health care insurance that they get no matter how lucrative the policy is. Eighty-five plus percent of the costs are paid for by a third party. The individual may or may not even look at the bill. With a system like that, it is no wonder we have costs that are out of control.

We have the best health care system in the world as it relates to quality. We have one of the worst as it relates to cost control.

Mr. BENTSEN. Thank you, Mr. Chairman.

Chairman NUSSLE. I would just say to the gentleman, one of the reasons why we added the word—and I think this committee took the lead on it—as opposed to just a prescription drug benefit was also modernization. I am not suggesting that answers your concern or mine or Mr. Walker's, but to try and add modernization reforms to it as opposed to just adding a prescription drug benefit to the program.

Mr. BENTSEN. I appreciate that, Mr. Chairman, on that, and I do not want to raise anybody's concerns about my supposed Keynesian leanings, but there is no free lunch.

Chairman NUSSLE. I am not suggesting that this is going to calm your nerves at all, but we did at least take the lead to add not just a benefit.

Mr. Watkins.

Mr. WATKINS. Thank you, Mr. Chairman. I think we have got a basketful of things that we have to resolve along the way, and I think we know it is either your children or your grandchildren saying there is a difference of needs and wants. Adults, as we look at what type of health care we are going to be including in the Medicare package and all the cost, all that will make a big difference in what the overall package will be.

I want you to elaborate a little bit in your equation here. You talked about how the sustainability does not rely on the economy, and you said solvency does not rely on the economy. I am having a little bit of a—I would like to hear you elaborate on that because I think solvency does depend a little bit on the economy, to say the least, in my opinion. But I am trying to work through that in my mind just a little bit in the overall long term picture of Medicare solvency. Where you are coming from on that?

Mr. WALKER. Well, the economy can have some effect on solvency because, obviously, to the extent that you have the more people working, making more money, they are going to be paying more payroll taxes. So it can affect payroll taxes. Solvency focuses on how much in assets does the trust fund have, and the assets, which are these U.S. Government bonds backed by the full faith and credit of the U.S. Government, they represent a moral, legal, political commitment. But by themselves they are not going to get the job done.

In order to convert those bonds into cash, the Congress is either going to have to raise taxes, cut spending or borrow from the public in order to do that. So that is what I mean when I say that, we need to recognize it is not that solvency is not important. The most important issue from an economic standpoint is are you going to be able to deliver on those promises, and are you going to be able to sustain depending on how big it is going to get as a percentage of the overall economy. The problem is not really today's retirees and people even close to retirement. It is boomers, X-ers, Generation Y. That's really the issue.

It is similar to the issue on Social Security, but the difference is the magnitude is so much greater, and the expectation gaps are so much greater than Social Security, and the emotion is so much higher, because when you talk about health care, it is a very important and emotional issue.

Mr. WATKINS. I will have to think about this—how solvency is not dependent upon the growth of the economy. Our overall budget depends upon the economy and the growth. I think Medicare depends on that economy. I think we cannot dismiss having a strong economic growth sustained over this long period of time.

Mr. WALKER. If we can grow the economy faster, OK, then hopefully we will be able to have more employment, and hopefully we will be able to have a situation where there will be more wages.

To the extent that the average wage goes up, then obviously you will generate more payroll tax revenues. However, let me be clear, this projection assumes CBO's most recent higher productivity growth assumptions. Therefore, this already has a lot of that already built into it. Obviously we want to try to do better, but the gap is so great, you are not going to solve the problem.

Mr. WATKINS. I have not had time to read your testimony. Can you tell me what the economic assumptions are that you base these figures on?

Mr. WALKER. We have used CBO assumptions. I will be happy to provide it for the record. We are not trying to compete with CBO. They are in the legislative branch.

Mr. SPRATT. Will the gentlemen yield for clarification?

Does that mean that you are assuming after 2016, the economy will grow at a productivity rate of 2½ percent per year?

Mr. WALKER. I can't recall the exact percentage, Mr. Spratt, that they used. I will provide it for the record.

Mr. WATKINS. That would make a big difference in overall things. If you would be able to provide it for the record.

[The information referred to follows:]

MR. WALKER'S RESPONSES TO QUESTIONS POSED BY MESSRS. SPRATT AND WATKINS

Mr. Spratt: Does that mean that you are assuming after 2016, the economy will grow at a productivity rate of 2½ percent per year?

Mr. Walker: No. From 2000 to 2016 labor productivity growth averages 2.1 percent per year. After 2016 labor productivity growth slows as the Federal Government's diminishing surpluses and then escalating deficits increasingly absorb national saving and reduce capital formation. The table of assumptions shows the CBO assumption for total factor productivity.

KEY MODEL ASSUMPTIONS

- Model assumptions for the first 10 years are generally based on CBO's January 2001 economic and budget assumptions. Spending, revenue, and interest follow CBO's baseline totals in which total discretionary spending grows with inflation.
- As in CBO's long-term work, the model uses calendar year—not fiscal year—data and is based on the National Income and Product Account (NIPA) framework rather than on the unified budget basis. This framework facilitates modeling of the Federal budget's effects on the economy. Our charts show estimated unified surpluses and deficits derived from this framework.
- After the first 10 years:

  Discretionary spending, mandatory spending other than health and Social Security, and revenue are held constant as a share of the economy at the same value as at the end of CBO's projection period.

  OASDI, HI, and SMI Trustees' intermediate projections are used for Social Security and Medicare spending. Once the OASDI and HI Trust Funds have been exhausted, the model assumes general fund financing of all current law benefits in excess of program revenues.

  For Medicaid, the model uses CBO's October 2000 long-term projections.

Source: GAO's March 2001 analysis.

TABLE 1.—MODEL ASSUMPTION SUMMARY

Model inputs	Assumptions
Surplus/deficit	CBO's January 2001 baseline through 2010; GAO simulations thereafter.
Social Security spending (OASDI)	2001 Social Security Trustees' intermediate projections.
Medicare spending (HI and SMI)	2001 Medicare Trustees' intermediate projections.
Medicaid spending	CBO's October 2000 long-term projections.
Other mandatory spending	CBO's January 2001 baseline through 2010; thereafter increases at the rate of economic growth (i.e., remains constant as a share of GDP).

TABLE 1.—MODEL ASSUMPTION SUMMARY—Continued

Model inputs	Assumptions
Discretionary spending	CBO's January 2001 baseline through 2010; thereafter increases at the rate of economic growth.
Revenue	CBO's January 2001 baseline through 2010; thereafter remains constant at 20.4 percent of GDP.
Nonfederal saving rate: gross saving of the private sector and state and local government sector.	16.1 percent.
Net foreign investment	An estimated 2000 nominal dollar level plus one third of any change in gross national saving.
Labor: growth in hours worked	2001 Social Security Trustees' intermediate projections.
Total factor productivity growth	1.5 percent (CBO's January 2001 assumption).
Inflation (GDP price index)	CBO through 2011; 1.9 percent thereafter (CBO's projection in 2011).
Interest rate (average on the national debt)	Average rate implied by CBO's January 2001 inflated baseline interest payment projections through 2005; 5.4 percent thereafter (based on CBO's assumption for the average rate on Treasury securities).

Notes:
1. These assumptions apply to our base simulation, Save Unified Surpluses. For alternative fiscal policy simulations, certain assumptions are varied, which are noted in the discussion of the alternative paths.
2. In our work, all CBO budget projections were converted from a fiscal year to a calendar year basis. The last year of CBO's projection period is fiscal year 2011, permitting the calculations of calendar year values through 2010.

Source: GAO's March 2001 analysis.

Chairman NUSSLE. Thank you.

Ms. McCarthy.

Ms. MCCARTHY. Thank you, Mr. Chairman.

I am trying to figure out how about to phrase my question without it sounding like I am bashing anybody, because I don't want to do that. Going back so many years ago, probably 20, 30 years ago, we basically took care of everybody in the hospital. We didn't know who had insurance, who doesn't have insurance. Obviously going back then, seeing that the cost of health care was rising, HMOs came into place promising that they would lower the cost of health care. Now, obviously we are seeing that the HMOs can't deliver that either.

I think what I am trying to go back is, not denying anybody trying to make a profit on their company and I think they should, I think that is what this company is all about, but I think they got themselves into a problem here because they are trying to deliver a health care system. Yet I was curious if there is any possibility of knowing what the cost analysis would be on what we have done on Medicare in delivering a health care system versus what the HMOs do and what it costs them to really deliver a health care system, especially since they are over cost. They have got to be high because they are still trying to make a profit.

I guess I come back from a person, as a health care provider, that I just don't see how anybody in health care can make money. You just can't. Because any monies that are made in a hospital—which very few hospitals would ever make money—it goes into the infrastructure, which means hiring more nurses. Now we have a crisis because now they don't have money to pay for nurses. Going down the system or any part of the health care system, whether you are an occupational therapist, doctor, they are not encouraging their children to go into the field. So our problem is a lot more complex.

So what I am trying to say is without going into—I am not one for universal health care because I have traveled around the world and we still have the best health care system as far as I am concerned. But we have a big problem. Because we all want good health care which I think we actually end up delivering. But how do we keep those costs down when the HMOs have to make a profit to sustain themselves and yet cut back on basic health care which most of us only use but let's face it as we get older and probably the last 3 months of anyone's life is probably the most expensive time for health care.

Mr. WALKER. We can sit here and talk about paying down the debt. As we come up with better technologies for health care, the technology that is coming down the pike is amazing. Anyone that spends time with the high techs where they say you are not going to have cancer or anything, we have the ability for that. But in the end, it is going to cost money. I don't know how anyone here in Congress is going to handle it particularly. First, my daughter-in-law is an R.N. so I am familiar with some of the challenges associated with that profession as well. Demographics are working against us. I mean, we have fewer and fewer workers supporting more and more retirees. The good news is people are living longer. By and large, they are living healthier, although in many cases, they want to retire earlier. And so you have a double whammy. You have a situation where people are going to be in retirement a lot more years. You are going to have a lot more people that are seniors where generally you are going to have more health care and yet they are not going to be paying in payroll taxes because they are exiting the work force earlier, if you will, sometimes because they can afford to, sometimes because they think they can afford to and they really can't afford to.

So this is a very big challenge by itself, but I also think it is part of a broader challenge. And part of the broader challenge is not only the issue of the overall budget outlook and the fiscal outlook, but it is also how long we end up dealing with slow workforce growth. How can we end up trying to encourage our citizens to contribute to the economy for a longer period of time, such that it not only will end up helping with regard to revenues, but it may also end up helping with regard to expenditures as well.

Ms. MCCARTHY. I think if you go shopping in Home Depot, you will see the majority of people working there are definitely way over the Social Security age. And number one, because they love working, but also because Congress increased people being able to earn some more money, they are back to work. I mean, I know last time I when shopping I had a number of senior citizens say thank you for passing that bill. They want to work.

Mr. WALKER. And that was a plus. Because otherwise it was a disincentive for them to work. So Congress took steps to try to do that. I think that is a positive thing to try to encourage people but not require people to do it.

Ms. MCCARTHY. Thank you.

Chairman NUSSLE. Mr. Fletcher.

Mr. FLETCHER. Thank you, Mr. Chairman. And Mr. Walker I appreciate this. I am sorry I didn't get into the first part of your testimony but appreciate you being here and Mr. Chairman for having

this hearing. Let me ask you from the chart and from what you have said, even though some folks say we can grow out where the GDP grows adequately out of Social Security, Medicaid, Medicare obligations, what you are saying, I think Mr. Watkins said this as well, it is very difficult. We are not going to be able to grow ourselves out of the demands and obligations we have under the current system. Is that correct?

Mr. WALKER. In theory we can. I wouldn't want to bet the ranch on these numbers.

Mr. FLETCHER. What kind of growth rate would we have to have in order to meet the obligations, any idea?

Mr. WALKER. I haven't calculated it, but we can try to take a stab at it and provide it for the record.

Mr. FLETCHER. We appreciate that. How much do we have in the securities and the trust fund worth, how many certificates do we have? What's the total value of that at this point?

Mr. WALKER. I think it is several hundred billion. But let me see if we can come up—we have the number. We will try to come up with that in a minute.

Mr. FLETCHER. What is their real worth in your estimate in the sense that are they worth anything?

Mr. WALKER. Anything that is backed by the full faith and credit of the United States Government is worth something. I think what we have to recognize is that they represent basically a promise to pay, a bond, but in order to be able to convert that bond into cash, in order to pay benefits, you are either going to have to raise taxes, cut spending or go out and borrow from the public in order to be able to do that. So yes, there is some value. But you can't pay the doctors with that bond, OK, and you can't, you know, buy groceries with that bond.

Mr. FLETCHER. So no intrinsic value, but there is a value in certainly the security of the promise that the U.S. Government would do that.

Mr. WALKER. Basically what you have is the trust fund basically says that the government has a legal, moral and obviously political obligation to be able to pay benefits in a timely manner to the extent of positive cash flows, to the extent that there is cash in excess expenditures plus the value of these bonds. When that runs out, then what happens? By the way, the number is $168 billion in the HI trust fund as of the end of fiscal 2000.

Mr. FLETCHER. What kind of interest does that accrue if they just sit there?

Mr. WALKER. It is an average of Federal obligations, I believe it is over 10- or 15-year maturities. I can provide that for the record. But it is based upon actual interest rates that are paid on U.S. obligations with stated maturities.

Mr. FLETCHER. How does what we do with the Medicare surplus, the annual surplus, what effect does that have on the solvency of the Medicare program?

Mr. WALKER. Whatever you do with the Medicare surplus will not affect solvency at all. It will affect sustainability, which is all the more reason why I say it is important to focus on sustainability, not just solvency. Because let me describe it. If you run a surplus this year of $10 billion in Medicare, you are required by

law to issue bonds to the trust funds, IOUs, bonds backed by the full faith and credit of the U.S. Government. You are required to issue those to the Medicare trust fund, no matter what you do with that $10 billion. You could spend that $10 billion in a prescription drug benefit, you could spend it on housing, you could use it for a tax cut, or you could use it to pay down debt held by the public.

Whatever you do has no effect on solvency. It does have effect on sustainability. And that is why I think we need to keep our eye on the ball that solvency is not the whole ball game. Sustainability is as much or more important.

Mr. FLETCHER. You said you have several options, in order to have solvency, in any one particular year, since the revenues coming in are what paid those year's obligations, can we meet those obligations if we say well, we don't want to raise taxes, we don't want to lower or increase the age of eligibility, do we have any other way other than reforming Medicare in the program of trying to make sure that we have sustainability and a yearly solvency?

Mr. WALKER. If you are not going to raise taxes and if you don't want to change the benefit structure under Medicare, then you are either going to have to cut discretionary spending significantly or you are going to have to end up going back into deficit financing, borrowing from the public to a greater and greater extent. But the problem is sooner or later you got to pay the piper. You know, as Mr. Bentsen said, "There is no free lunch."

Mr. FLETCHER. Would there be the possibility of reforming the system in the way that it works that might help insolvency? You mentioned changing the particular things that we cover.

Mr. WALKER. I think realistically one of the things that Congress is going to need to consider over time is what is the nature of the promise in the Medicare system. And whether or not the promise should be the same that it is today, which is to provide a defined level of coverage that is the same for everybody, irrespective of their means, irrespective of how much they paid in, or whether or not it is something different and whether or not there might be several levels of coverage, some of which everybody might get based upon their taxes; others might want to be able to buy more coverage and if they do that, then they might have to assume some obligation.

I think you are going to have to look at what is the nature of the promise. That could vary by generation. You could say, for example, that for today's retirees or near-term retirees, it is the current deal. Because that is what they expected, they don't have time to make adjustments. It may not be feasible, it may not be fair to do anything different than that. But for those that are further away from retirement, you could decide that you want to end up making some changes, that while they still have time to do something about it, try to plan for it.

But I also think that there are things that can and should be done within the context of the current system. And I think the second panel is going to end up talking about some of those things. We spend a tremendous amount of money on administrative, you know, paperwork costs in this system, and it is staggering.

Mr. FLETCHER. Thank you, Mr. Walker.

Chairman NUSSLE. Mr. Walker we have two votes that have been called on the floor. We need to recess the hearing. Do we have others that would like to inquire? Are there others? Mr. Collins would like to inquire.

So what we will do is we will recess, my understanding is you have been gracious enough to sit through the vote and to allow us to do that. So we will recess and after the second vote we will come right back, and at that point Mr. Collins will be recognized. Hearing is in recess.

[Recess.]

Chairman NUSSLE. This will resume the hearing on Medicare and the need for reform. My understanding is Mr. Walker has a meeting with the Senate at 12:15. He needs to leave here at noon. We will get right into this.

Mr. Collins.

Mr. COLLINS. Thank you, Mr. Chairman. And thank you Mr. Walker. Your comments kind of remind me of the story about Harry Truman when he was delivering a speech and someone said, "Give 'em hell, Harry." He says, "son, I am telling the truth; they just think it's hell."

I appreciate your comments. Solvency should not be the focus. It is cash flow. Cash flow is the focus. Cash flow will be the sustainability. The cash flow of this trust fund, other trust funds and the Federal Treasury depend on the cash flow in the private sector, period. That is where we generate revenues is from the private sector and from that cash flow.

When you look back over the last 40 years, in the 1960's, under President Kennedy, and he said to a rising tide, lift all boats and the Congress then passed meaningful tax relief. What were those funds used for in the 1960's? What happened with that stimulus of that immediate influx of new money into the Treasury? The great society, Medicare, Medicaid, and the welfare program?

Now we have addressed the welfare program to a certain extent, the other two are still there. Then in the 1980's, with a large tax reduction, to leave the cash flow in the private sector and drastic increase of revenues to the Federal Treasury, what were those funds used for? They were used to, as President Reagan said, to end the evil empire. That was the cold war. Bring down the Soviet Union, the Berlin Wall, and people think that was a good investment and it was.

The most recent tax cut to increase the cash flow of the private sector, hopefully will have the same meaning. It won't be as fast because budget law restricted us on how politically we could make those tax reductions and increase that cash flow in the private sector. But why do we need a new influx of money into the Treasury now? You have been talking about it sir. We have got to address Social Security/Medicare. Medicare does have far greater problems than Social Security. And it is going to take general funds to address both, to be able to sustain both.

I am concerned about Medicare. I am concerned about it because it is congressionally managed. It is a job run government HMO, very inefficiently operated, as you so outlined, based on meeting needs and increased care in costs. And we are experiencing an increase in the cost of health care across this country. I am afraid

some of the things that we are dealing with here in the Congress today will only increase costs more and will reduce access for many people across this country to health care. And I am talking about the patients Bill of Rights.

We again, therefore, are trying to manage from Congress health care in this country. What is going to be the coverage, what will be in the plans and how they will be mandated. That will increase costs. And there are a lot of people who are insured today or people who are providing them with that insurance or assisting them with that insurance won't be able to meet that cost. Therefore, we will have a reduction to health care and coverage in this country. You mentioned incremental change. The changes that we make in Medicare will have to be incremental because politically we can't bite the bullet and do it all at once.

The main thing that the people have got to understand that those who are covered under Medicare or Social Security today, they won't see any drastic changes except maybe some improvements in what they are already receiving, their wants, as you say. But there won't be any reduction. That is the incremental change. It is the generations behind me. I am one of the baby boomers, but the generation behind me and the one behind them, they have to see change coming and they will be more prepared for the change based on the daily lives they lead today and what they have access to.

It all reminds me of the definition of a democracy. And that is, a democracy is indefinite because those who are governed under a democracy will learn of the benefits they can reap from its Treasury, and they have a tendency to elect people who will enhance those benefits leading to the demise of the democracy. The sustainability of the government, the sustainability of its programs whether it is Medicare, Medicaid, Social Security, defense, whatever, depends on the ballot box and what happens with those, by those who are elected.

I appreciate your comments, your forwardness, your frankness because these are reeling issues that have to be dealt with to sustain this republic, this democracy. Thank you, Mr. Walker.

Chairman NUSSLE. Mr. Moore.

Mr. MOORE. Thank you, Mr. Chairman. I regret that I had attended another markup in another committee meeting. I wasn't able to be here, so I don't want to ask any questions at this time and repeat what might have already been asked, but thank Mr. Walker for appearing today.

Chairman NUSSLE. Mr. Kirk.

Mr. KIRK. I note that with Mr. Scanlon's testimony we are about to see we have got some real problems with the information provided by carriers regarding the incredibly complicated Medicare regulations. I wonder if you could expand something on the problems that we have got: 8 out of 10 web sites that you found with inaccurate information on Medicare billing procedures, 85 percent of the calls—the 60 calls—85 percent of them gave inaccurate information, and five out of nine carriers had wrong information in their Medicare billing.

Those are pretty dramatic numbers on an ability to deal with the hopelessly complicated system. I wonder if could you comment on the work you have done.

Mr. WALKER. Well, first there are some problems with regard to customer service and the reliability of information that is being provided. It is a very, very complicated program. The people at CMS are under a constant pressure, frankly, to do more with less. They face some of the same challenges that the Internal Revenue Service faces with regard to the accuracy of some of the information that they have been providing to taxpayers. There are some similarities. Quite frankly, you know how complicated the tax code is. Quite frankly, Medicare is probably as much or more complicated than the Tax Code.

We also have another problem as it relates to data, that is, we don't have enough timely, accurate, useful information in order for the Congress to be able to make informed decisions in this area and in order for CMS to be able to effectively manage the program.

Health care is over 13 percent of our economy and growing. Unfortunately when the Congress has to consider, for example, whether to make adjustments in BBA, all too frequently it has had to make these decisions based upon the assertions of the providers rather than a hard core analysis of the facts. We need to do something on both sides, customer service as well as to get more timely accurate useful information so the Congress make more informed judgments and timely judgments and so CMS can better manage the program.

Mr. KIRK. I wholeheartedly agree. We have another big issue, and I am wondering if it will play in your future look at the expanding cost of the system. I note here that we have got the new trustees intermediate assumption report and they have some pretty dramatic changes from the level of growth we had before. But I noted that the State of Florida has made a major decision, and this is with regard to case management. One of the realities in Medicare today—well, in all health care, is poor patient compliance with doctor's orders that we do not have the prescription drugs taken on time or in the right quantities and other procedures are not followed.

To sum up, my understanding of case management, it is hiring a few doctors—but mainly nurses—to keep in contact with the patient and dramatically increase compliance with doctors' orders making sure that the medicines are taken on time and in the right quantity and other procedures are followed. My understanding is the record of case management is the health status of the patients dramatically improves as we dedicate resources to providing necessary compliance follow-up. Costs fall to the point where one major drug company has made an offer to the State of Florida to keep costs at a certain level, and they will take any profit. They bet that they took a good risk with the State of Florida, and they will take all the risk.

It is a dramatic cost savings that this one company has promised the State of Florida using this procedure. Do you see this in any way as trend? Can case management contain Medicare costs?

Mr. WALKER. You are speaking of one element of case management, Mr. Kirk. I would make a brief comment on it, then I would

suggest that Dr. Scanlon, who heads up our health care team who is going to be on the next panel, might be able to develop the subject a little deeper than I am. Clearly, there are opportunities to capitalize on these practices. In some cases, it means spending a little bit more money now in order to save money later. That is one of the things that we need to keep in mind. We need make sure that you know, CMS has adequate resources to be able to do its job now and we can't just focus on you know, what the immediate impact is of some of these things.

We also have to think about what the impact is over time and the compounding effect. There are some things we can do that can compound for us rather than compound against it, and this may be one example of that.

Mr. KIRK. Last follow-up. The Congress no doubt will provide a prescription drug benefit. As we provide public resources to do that, our prescription drug intake will increase the out payment consumption. Do you see that with increasing access and affordability of medicine, improving the health status of the patient population at all, will decrease the future costs of the system? Is there any—for lack of a better word—cost savings response to the system as patients have greater access to affordable medicine?

Mr. WALKER. Based upon data that I have seen, and I do not believe that we have done an extensive analysis of this, let me say that up front, but based upon data that I have seen is that clearly there are some types of prescription drugs that can result in not only improved health status, but also decreased health costs as compared to more intrusive procedures. However, in the aggregate prescription drugs under the current environment result in a net cost increase, not decrease, because not all prescription drugs fall into that category.

Mr. KIRK. Thank you, Mr. Chairman.

Chairman NUSSLE. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman. Mr. Scanlon, or Dr. Scanlon, in your testimony, you said that if there were no benefit cuts or increases in payroll taxes, then we will end up cutting discretionary spending or end up with deficit financing. That was predicate you put into this whole process. Now——

Mr. WALKER. Or raise taxes. That is an option.

Mr. MCDERMOTT. That is what I said. You have got to do something with payroll taxes if you don't. If you—we have heard a lot talk about Medicare reform and Medicare modification, and people talk about competition and that is going to drive down costs and so forth. I sat on the Medicare Commission for a whole year and listened to this business about how competition would work and the commission came up with the Breaux-Thomas proposal. It didn't pass the Commission, but there were significant number of people, a majority who thought that was the way to go.

Now, we have Breaux-Frist and Breaux II, and—I would like to hear your view. That seems like an alternative to cutting benefits or increasing payroll taxes or cutting discretionary spending or going into deficit financing. There might be a better way to do it. Do you think Breaux-Frist or Breaux II or—you pick your poison on that one, I don't really care which one you want to talk about,

any of those competitive models really hold forth any possibility of saving money?

Mr. WALKER. I believe that first competition can help but it is not panacea. It can be an element of a much broader array of actions that will be necessary, ultimately, to deal with this. Obviously, I don't want to endorse any particular legislative proposal. I will just make some generic comments.

Mr. MCDERMOTT. God forbid you should do that.

Mr. WALKER. It is not my job, I don't have a vote. I will say that there are certain elements of Breaux-Frist in its various versions that represent a fundamental shift in how we have historically looked at Medicare. And I do think that ultimately the Congress is going to need to debate such things as what is the promise to the beneficiaries. What is the promise to the providers. Because there are huge expectation gaps, and obviously we have mismatches between what has been promised right now, which is a defined level of coverage for everybody, no matter what their circumstance is, and we have got a huge financing gap.

Mr. MCDERMOTT. Are you talking, then, in code language about vouchers?

Mr. WALKER. No. No. I am not necessarily talking about vouchers. I mean, for example, you could say, that you want to provide guaranteed access to health care, guaranteed insurability, for—then could you say, what level of coverage do you want to make sure that everybody has, which may be somewhat less than what you have right now, although could you say for current retirees and near-term retirees, you get the current deal because they don't have time to make adjustments to what their expectation has been. It may not be fair to do that.

But for people like myself, baby boomers or like my kids, you Generation X, or like my grandkids, I only have one right now, you could end up deciding that you want to end up defining the level of coverage that is provided.

You can get more if you want. But you may have to end up coming out-of-pocket if you want to end up having more coverage in order to try to increase incentives for more rational choices, enhance transparency, both as to cost and to quality.

So I think one of the things that Breaux-Frist proposal does do, is it tries to get into some of these basic issues. What is the nature of the promise?

Mr. MCDERMOTT. Is that a sophisticated way of making a benefit cut? Because if I am 65 and I have the program, you are not going to cut me, you are just going to cut it for my kid who is coming down the road. Since he doesn't have the benefits, at this time, you are not cutting his benefits. It is just when he gets here, he will get a lower level of benefit, and therefore you can't define that as a benefit cut?

Mr. WALKER. Well, candidly, I think Mr. McDermott, that we have done work on Social Security reform as well, let me give that as an analogy. All the work that we do on Social Security reform, we end up analyzing all the reform proposals based upon a standard series of questions, because there are positives and negatives to every reform proposal when we compare it to two scenarios, one is promised benefits and the second is funded benefits. I think it

is relevant to consider the same for Medicare, because the fact of the matter is we have promised "X," but we only have adequate funding to fund some percentage of "X." Therefore, like pensions, before ERISA was passed, the Employee Retirement Income Security Act, there are a lot of employers out there that made a lot of promises that they never delivered on. They never delivered on their promises.

So I think we not only have to look at promised benefits, we have to look at funded benefits. Because ultimately, over time, I hope that the Congress, whatever it promises to my children, whatever it promises to my grandchildren, I think it is important that it be able to deliver on that promise. Right now I don't think you are going to be able to deliver on what you promised.

Mr. MCDERMOTT. Is that because you don't think there is enough money in this country or is it because the mechanisms we have for collecting it and applying it to the program at the moment are unsatisfactory?

Mr. WALKER. I think it is a multiplicity of issues. I think part of it is the fact that our current system doesn't have adequate incentives, transparency and accountability. Therefore that is fueling a lot of our problems. Part of it is because of known demographics. Part of it is because people want unlimited health care. Part of it is because I think there is a practical limit as to how much the American people will allow themselves to be taxed. I don't know what that limit is. I don't know that anybody knows that. Part of it is because my kids and grandkids are going to want government to be able to do some things in the discretionary spending category. And they are probably going to want some choice about what that is. They don't want all those choices to have been made for them by you and me.

Mr. MCDERMOTT. Do you think they have been presented with an opportunity to find out what the maximum is they would pay for health care? Do you think we have max'd out in health care? Maybe in overall taxes, yes. But how about in health care? Have we max'd out on what people would be willing to pay?

Mr. WALKER. If you want to look at it on that basis. And if you look at the surveys, for example, take employer surveys because those people aren't eligible for the most part for Medicare yet, the number one benefit of choice is health care. The number 2 benefit of choice is health care. Number 3 benefit of choice is health care. That is where the demand is, OK? Obviously, there is a limit as to how much people are going to pay. But to what extent can you use that as part of the equation? To what extent can you say, gee, let us provide you some choices? Let's let you make more decisions as to how much of your resources you want to put up. Make sure that the government has a promise that it can deliver on that is universal and then potentially consider some other options that people can make some of their own choices about how much of their resources do they want to put aside in order to lay off risk. That is what insurance is.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman NUSSLE. In the final minute before you have to leave, I do have a question that a member wanted to ask and had to leave. I appreciate your time. Does it matter whether Medicare pre-

scription drugs are funded out of part A or part B or other sources, and would that decision impact the solvency and sustainability of the Medicare program?

Mr. WALKER. First, right now, the only thing that the program is really focused on from a solvency standpoint is part A because part A is funded with payroll taxes, which is intended to adequately finance it over a long period of time. Part B is the SMI program, which is really a term insurance program. It is just supposed to have enough cash to be able to pay current benefits and claims incurred, but not reported at the end of the year. My view is the most important thing is sustainability. Therefore, whether you pay for it out of A or B wouldn't affect sustainability because sustainability deals with the combined Medicare program, and what percentage of the budget and what percentage of the economy does this represent rather than solvency, which although has some significance, I think is not the key issue.

Mr. BENTSEN. Could I ask a question for the record and then you can get back to me on this. I appreciate your entire testimony and think it is very interesting. A lot has been said about the trust fund, both here and for Social Security, the credit worthiness of the trust fund, the impact or the claims that that has against the future potential growth of the economy, et cetera. Could you provide a response to two hypotheticals putting aside the philosophical issues?

What would be the difference had we taken the trust funds, both Medicare and Social Security and rather than invest them in government funds, invested them in utility bonds, AA utility bonds—I don't know if there are any AAA utility bonds, but AA utility bonds or an index, where it would have been a separate corpus than being in government bonds, and thus not a bookkeeping entry form. What would be the difference there?

And you have to clarify between well, the government were to run huge deficits and run up debt because I think that would underscore that there is a real trust fund. So if you could respond to me on that. And the other is—and that gets to your other point, rather than have payroll taxes for this program—and I think the same would be said for Social Security, but since we are talking about Medicare, rather than fixing payroll taxes for the purposes of establishing long-term solvency in a trust fund, what would be the merit or the pros and cons of having a floating payroll tax so that you never run a surplus—arguably never run a deficit either and that way again, you don't have these trust funds questions?

Mr. WALKER. Of course, on the latter, you may not have a surplus or a deficit. You would have some cushion obviously, because you don't know exactly what the costs are going to be. On the other hand, you are going to backload these obligations. Tax rates are going to be going up, up, up, up, up. Part of the problem is us you have to end up looking at this as a piece of a bigger picture. There is a tendency to say, gee, what are we going to do to solve Social Security? What do we need to do to solve Medicare? What do we need to do to solve Medicaid?

The problem is is that we believe—and I will provide something for the record—you just can't look at the single issue, but the aggregate, because money you use to solve problem X is not available

for Y. And in the end, there is some practical limit as to how much total tax burden is going to be and to how much pressure you are going to want to put on discretionary spending.

Mr. BENTSEN. The bigger issue that you raise and I think you raise it very well, it is society. It is not just the government. This could be the private sector, and we could be saying are we spending too much on GDP or not enough on GDP on this particular issue?

Mr. WALKER. I think it is clearly a societal issue, and I think that in the end, it is just not dealing with Medicare, it is dealing with health care broadly defined because it is just not a Medicare problem. It is much bigger.

Chairman NUSSLE. Thank you. Mr. Walker, you never fail to provide us with good information. I want to compliment you and your entire shop. The General Accounting Office does a very valuable service to the Congress, and it is one of those areas that, unfortunately, we don't give enough praise to. We really appreciate good news, bad news and everything in between. You give it to us straight. I'm very serious when I say on behalf of all the members of this committee, we appreciate the service that all of you provide to the Congress and to the Nation.

Mr. WALKER. Thank you, Mr. Chairman. I am pleased to lead an outstanding group of professionals, and we look forward to continuing to work with the Congress.

Chairman NUSSLE. And we got you out of here pretty close to on time. We appreciate your time today.

Our second panel today includes three distinguished individuals who will provide us some more information with regard to Medicare and the need to reform. We have today Frank Pallone, Member of Congress, a colleague, who will—who is the co-chairman of the Democratic Task Force on Health Care Reform. We appreciate his—and we have been trying to get his schedule and our schedule together and he will be here shortly; Mr. King-Shaw, deputy administrator for Centers for Medicare and Medicaid services, CMS; and Bill Scanlon, who has been referred to quite a bit today and we appreciate your attendance, also from the General Accounting Office, director of health care issues.

STATEMENTS OF RUBEN JOSE KING-SHAW, DEPUTY ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES; BILL SCANLON, DIRECTOR, HEALTH CARE ISSUES, U.S. GENERAL ACCOUNTING OFFICE; AND FRANK PALLONE, JR., A REPRESENTATIVE OF CONGRESS FROM THE STATE OF NEW JERSEY, CO-CHAIRMAN, DEMOCRATIC TASK FORCE ON HEALTH CARE REFORM

Chairman NUSSLE. And so we invite all three of you to come forward at this time. And what I will do, because I know Mr. Pallone has a number of very important things he needs to be doing, I will take him when he arrives.

What we will do to begin with is to being with you, Mr. King-Shaw, deputy administrator for the Centers for Medicare and Medicaid Services, the name that I blew earlier and I apologize for that. It was so easy to remember HCFA. Now we have to think of new names. We appreciate your services and your entire testimony

will be in the record and the time you have. You may summarize your testimony. Welcome.

STATEMENT OF RUBEN JOSE KING-SHAW

Mr. KING-SHAW. Thank you, and it is good to be here, Chairman Nussle, Congressman Spratt, distinguished members. Let me first say that as deputy administrator and chief operating officer of CMS, I am responsible for many of the issues that were discussed earlier in terms of responsiveness and customer service, so it is a pleasure for me to talk about what I do and what the plans are. We openly admit that we have had issues in many of the service areas at CMS. And that was part of the thinking of bringing in somebody as chief operating officer to focus on the day-to-day operations and the customer service issues as well as implementation of new initiatives, new policies.

And so it is in recognition of all that that I will summarize the testimony that I provided for you in writing. Since the topic that was assigned to me was more on the physician relation and burden and paperwork issues, my summary will focus on those. Clearly, many physicians have communicated to us, as have health care providers and Members of Congress that there are serious concerns, grave concerns, even about the regulatory environment and the paperwork involved with the Medicare program. We appreciate those concerns. We have been working within CMS to identify those concerns and correct them.

Essentially, it is imperative to preserve the viability, the longevity, the stability of the Medicare program; that we streamline many of the Medicare requirements; that we restore or perhaps bring, for the first time, the spirit of openness and responsiveness to the agency; and see to it that the regulatory environment, the regulations that govern the Medicare program are sensible and predictable, something we'll talk about in a few moments. Medicare program will pay approximately $240 billion in health care claims this year for almost 40 million beneficiaries. It is perhaps the largest insurance company, if you will, in America. And so something that big obviously will have some rules—must have some structure to it. But those rules should not undermine the physician-to-patient relationship. It should not disrupt medical care. In fact, it should help and not hinder our efforts to assist people and it must control costs, but also must ensure quality, and those rules must be consistent with our efforts to control fraud and error.

And so as we go through this review of our rules, these are things we are specifically looking to do. One is to listen to Americans and those who provide care to Medicare beneficiaries. And what we hope to learn are those things that we can do within our auspices, our own authority in a very short-term to relieve some of these burdens and those things that obviously we have to work with Congress to rectify. So in that vein, the Secretary has already established a regulatory reform group that specifically will be looking at current rules that must be better explained, a separate set of rules that need to be streamlined, and potentially a third category of rules that will be cut all together.

The simplicity of these rules will be very important. So much of an industry has been built up to explain what formerly HCFA, cur-

rently now called CMS, really means. And so much of the rules that are developed and the infrastructure around those rules come from a lack of clarity or in many cases, an inconsistent interpretation of those rules.

Therefore, the Department of Justice or the OIG and CMS would do well to have a common understanding of what the rules mean, so that all of our interaction with the provider community can be in a more coordinated fashion. So we will be having a series of listening forums around the country to better understand what the day-to-day practitioner and provider is experiencing with the Medicare program and coming up with action plans on how to fix those. And obviously beneficiaries will be a key part of that.

We will have a number of open door policy committees, where a senior staff member at CMS will be responsible for reestablishing, restructuring a relationship between CMS and a provider group. I have the pleasure of performing that task for the physician community, The House of Medicine. Others will focus on hospitals, long-term care nursing homes, etcetera. The improved communications will go a long way toward directing our efforts in how to come up with specific action plans to relieve the stress and make valuable changes. And third, we will have a team of in-house experts. When I say "experts," within CMS, specifically, but often what you find that deep in the rank and file of any organization, are people who know a great deal about these programs, and when asked, will tell you how to fix it or some new, innovative ideas.

So we hope to listen to our own employees who put years into the system who have quite valuable insight that when empowered and uplifted can release all kinds of creative energy to solve these problems, but others as well from around the country. The other thing we are looking to do is to have a more regular release of information, a quarterly compendium so that the world will have one place to look on a quarterly basis about all the upcoming changes that are on the docket, if you will, for the Medicare program, just relieving the stress and expense of trying to figure out where CMS is going.

There will be a definitive document that will tell us that. We are looking into electronic rule making. And we are looking at ways to improve our communications with physicians at large through the Internet and paper and seminars and all kinds of ways we don't do now. We intend to do some things around the rural and urban settings that may not connect well to Internet-based communication strategies.

And as I will openly say to you, we will need to spend much more effort in our oversight of contractors. So much of the provider relationship is built on the conversation or lack thereof between contractors and the provider community. We will do things such as better oversight of their web sites, their contractor call center performance, their provider relations efforts, and look at ways we should perhaps nationalize our provider relation function and communications rather than leaving it completely to a local-by-local market process.

So we hope we will begin our conversation today and not just have a conversation today. We are very excited about the new things on the horizon and look forward to working with you and

all the Members of Congress to lead us to a higher glory. When questions are asked, I'll be happy to answer them.

Chairman NUSSLE. Thank you very much.

[The prepared statement of Mr. King-Shaw follows:]

PREPARED STATEMENT OF RUBEN JOSE KING-SHAW, DEPUTY ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Chairman Nussle, Congressman Spratt, distinguished committee members, thank you for inviting me to discuss the Centers for Medicare & Medicaid Services' (CMS's) work to streamline Medicare's regulatory processes and our provider and beneficiary education efforts. Many physicians, health plans, providers and Members of Congress have raised concerns about Medicare's regulatory and paperwork burden and the cost of doing business with the Medicare program. We can appreciate these concerns, and are taking every effort to identify and address areas where improvements can be made. Physicians and other health care providers play a critical role in ensuring that Medicare beneficiaries receive quality health care. We know that to make sure that beneficiaries continue to receive the highest quality care, we must streamline Medicare's requirements, bring openness and responsiveness into the process, and make certain that regulatory and paperwork changes are sensible and predictable. In the coming months, we will take aggressive action to meet these critical goals.

In June, Secretary Thompson and Administrator Scully announced that as a first step in reforming the Medicare program, they were changing the Agency's name to the Centers for Medicare & Medicaid Services. The name-change is only the beginning of our broader effort to change the face of the Medicare program and bring a culture of responsiveness to the Agency. These are not empty words: creating a "culture of responsiveness" means ensuring high-quality medical care for beneficiaries, improving communication with providers, beneficiaries and Congress, and redoubling our education efforts. As we work to reduce Medicare's regulatory and paperwork burden and further improve our provider education efforts, we look forward to our continued partnership with Congress and the physician and provider community.

BACKGROUND

This year, Medicare will pay approximately $240 billion for the health care of nearly 40 million beneficiaries, involving nearly one billion Medicare claims from more than one million physicians, hospitals, and other health care providers. CMS strives to ensure that Medicare pays only for the services allowed by law while making it as easy as possible for qualified health care providers to treat Medicare beneficiaries. We have to carefully balance the impact of Medicare's laws and regulations on physicians and other providers with our accountability for billions of dollars of Medicare payments.

Medicare's requirements, as outlined in the law, generate many of the concerns that our constituents bring to your attention and mine. Of course, there is a genuine need for some rules. But rules should exist to help, not hinder, our efforts to assist people, help control costs, and ensure quality, though the rules must remain consistent with our obligation and commitment to prevent fraud and error. When regulations, mandates, and paperwork obscure or even thwart the services providers are trying to give, those rules need to be changed. Our constituents, the Americans who depend on Medicare, and the physicians and other health care providers who care for them, deserve better. And so we are working with the Secretary to reform the way Medicare works, making it simpler and easier for everyone involved. We are dedicating ourselves to listening closely to Americans' concerns, learning how we can do a better job of meeting providers' needs, and serving them in the best way we can. We also have to ensure that we focus our efforts appropriately, and that means being less intrusive to the providers who participate in Medicare and more responsive to the beneficiaries who depend on Medicare.

IMPROVING AGENCY RESPONSIVENESS

As I mentioned, we are taking aggressive steps to bring a culture of responsiveness to CMS. This culture, this spirit, is rooted in a commitment to compassion and responsibility to beneficiaries and the physicians and providers who serve them. We intend to reinvigorate the entire Agency with a spirit of responsiveness to our constituents—to you, Members of Congress; to our colleagues in government here in

Washington and throughout the Nation; and to the men, women, and children our programs protect. To promote responsiveness, the Agency is:

Creating Senior-Staff Level Primary Contacts for beneficiary groups, plans, physicians, providers, and suppliers to strengthen communication and information sharing between stakeholders and the Agency. We recently designated senior-level CMS staff members as the principal points-of-contact for each specific provider group, such as hospitals, physicians, nursing homes, and health plans. These designees will work with the industry groups to facilitate information sharing and enhance communication between the Agency and its business partners. The designees will help ensure that each of these important voices is heard within CMS. I will discuss this effort in greater detail later.

• Enhancing Outreach and Education to providers, plans, and practitioners by building on the current educational system with a renewed spirit of openness, mutual information sharing, and partnership. The Agency is developing and improving training on new program requirements and payment system changes, increasing the number of satellite broadcasts available to health care industry groups, and making greater use of web-based information and learning systems for physicians and providers across the country.

• Establishing Key Contacts for the States at the regional and central office level. Similar to the senior-staff level contacts for industry and beneficiary groups, these staff members are available to work directly with the Governors and top State officials to help eliminate Agency obstacles in obtaining answers, feedback, and guidance. Each State now has one Medicaid staff member assigned to them in the regions and another in Baltimore, both of whom are accountable for each State's specific issues.

Responding More Rapidly and Appropriately to Congress and External Partners by promptly responding to their inquiries. We are developing an intra-Agency correspondence routing system and timeliness standards to respond more efficiently and promptly to congressional inquiries. We also are also exploring ways to make data, information, and trend analyses more readily available to our partners and the public in a timely manner. In addition, CMS will make explicit and widely publicize the requirements for obtaining data and analyses from us, including protecting the confidentiality of the data.

REGULATORY REFORM

A culture of responsiveness alone will not alleviate the regulatory and related paperwork burdens that far too long have been associated with the Medicare program. Thus, the Secretary is forming a new regulatory reform group to look for regulations that prevent hospitals, physicians and other health care providers from helping Medicare beneficiaries in the most effective way possible. This group will determine what rules need to be better explained, what rules need to be streamlined, and what rules need to be cut altogether, without increasing costs or compromising quality. To assist this group, we have developed a multifaceted approach, focusing on listening and learning, which will get us on the right track. This methodical, sector-by-sector approach will enable us to administer our health care programs as effectively and efficiently as possible.

Under the first aspect of the plan, CMS will conduct public listening sessions across the country to hear directly from physicians and health care providers away from Washington, DC, and away from Baltimore, and out in the areas where real people live and work under the rules we develop; where these people may not have such easy access to policymakers to share their good ideas and legitimate concerns. Most of you in Congress have these kinds of listening sessions with your local constituents on a regular basis. We want to hear from local seniors, large and small providers, State workers, and the people who deal with Medicare and Medicaid in the real world. We want to get their input so we can run these programs in ways that make sense for real Americans in everyday life. We hear from some of these people now, but we want to get input from many, many more.

We want to hear from the broad range of providers, from those in rural offices and inner city clinics to the suburban health centers and urban hospitals. We want to hear from the large hospital systems and the small, two doctor practices and the solo providers. We want input from folks like group practice managers, physician assistants, and nurses. These professionals who are in the field every day can give us good ideas that improve our management of these vitally important programs. This type of input is good for our beneficiaries because regulatory reform will allow physicians and providers to spend more time caring for beneficiaries, and it will encourage physicians and providers to remain in the Medicare program.

The second aspect of the plan is to meet with the various health-sector workgroups—these are the industry folks here in Washington. Some of the people who we hear from the most are the individual and institutional providers who are dealing with our rules every day. They are the ones caring for our beneficiaries, and they are the ones filling out many of the forms, trying to understand the rules, and working to do the things they spent years training to do—making people healthy. And so the second aspect of our approach will focus specifically on the collective expertise of the industry groups who represent these physicians and providers, working with CMS senior staff. We are convening seven health-sector workgroups with a senior CMS person as each group's principle contact. The purpose of these groups is to suggest ways that we can improve their interactions with CMS and the Medicare program to reduce regulatory complexity and burden. For example, the American Hospital Association (AHA) recently released a report, "Patients or Paperwork: The Regulatory Burden Facing Hospitals." The AHA found that due to regulatory burden, every hour spent providing actual patient care generates at least 30 minutes—and sometimes an hour—of paperwork. We need more input like this to improve our operation of Medicare, so that health care professionals can spend more time delivering the care for which they were trained, and so that beneficiaries can spend more time with their doctors and other providers—not in waiting rooms.

Like the physicians, providers, and beneficiaries who live and work with Medicare every day, CMS staff have dealt with the system for years, and they have suggestions about how we can operate the Medicare program more simply and effectively. They certainly have heard from all of you and from many, many providers about what could be fixed. To examine these important concerns, the third aspect of our plan is forming a group of in-house experts from the wide array of Medicare's program areas. We are asking them to think innovatively about new ways of doing business, reducing administrative burdens, and simplifying our rules and regulations, without increasing costs or compromising quality. Today, providers are forced to spend more time keeping up with the latest rules and interpretations rather than keeping up with providing patient care. Frankly, the complexity of the program makes it difficult for those of us who administer it to keep up. It is difficult to educate beneficiaries, providers and our business partners when there is so much complex information to explain. This group of experts will develop ways that we can reduce burden on providers, eliminate complexity wherever possible, and make Medicare more "user-friendly" for everyone involved.

In no way will we diminish our interest in fighting waste, fraud and error in the Medicare program. Most physicians and other providers are honest and want only to be fairly reimbursed for the high-quality care they provide, but for the small percentage of people who take advantage of the system, we will continue our aggressive efforts to protect the funds that taxpayers have entrusted to our use.

These outreach efforts will allow us to hear from all segments of people who deal with Medicare and Medicaid, from the beneficiaries and the public at large, to the physicians and providers, to the CMS employees. We are going to listen to them, and we are going to learn how we can do a better job. But listening is not enough. Getting together and generating great solutions is not enough. So we are going to take action. To improve the way we do business and make Medicare and Medicaid easier for everyone involved with them without increasing costs or compromising quality, the Secretary and Administrator have already announced some important changes and we plan to announce more in the coming weeks.

STREAMLINING THE REGULATORY PROCESS

In addition to easing the regulatory burden on health plans, physicians and other providers, we are working with providers and Congress to streamline the regulatory process. Although the Agency has made some progress on this front, we still have important work to do. We are committed to making common-sense changes and ensuring that the regulations governing our program not only make sense, but also are plain and understandable. The Secretary has made this a priority for the Department and we are committed to this effort. Streamlining will go a long way toward alleviating providers' fears and reducing the amount of paperwork that has all too often in the past been an unnecessary burden on the providers who care for Medicare beneficiaries. In the coming months, with the leadership and support of Secretary Thompson, we will take important.steps toward reaching these goals.

As a first step, we will develop a quarterly compendium of all changes to Medicare that affect physicians and other providers to make it easier for them to understand and comply with Medicare regulations and instructions. The compendium will be a useful document for predicting changes to Medicare's instructions to physicians and providers, and will contain a list of all regulations we expect to publish in the com-

ing quarter, as well as the actual publication dates and page references to all regulations published in the previous quarter. All changes—both regulatory and non-regulatory—will be treated the same, regardless of whether the change results in increased or decreased payment, coverage, or reporting burden. The compendium will be published only at the beginning of a quarter, unless the Secretary or Administrator directs otherwise. By publishing changes in the quarterly compendium, physicians and other providers will no longer be forced to sift through pages and pages of the Federal Register—or pay someone to do it for them—for proposed rules, regulations, and other changes that may effect them. The compendium will include all program memoranda, manual changes, and any other instruction that could affect providers in any way. It will provide predictability, and will ensure that physicians and other providers are fully aware of Medicare changes and that they have time to react before new requirements are placed on them.

In addition to the quarterly compendium, we will develop a system of electronic rulemaking to make the rulemaking process more efficient and to reduce the flow of paper between providers and CMS. Today, in an effort to make updated regulations more readily accessible, we routinely post them on our website, www.hcfa.gov. These postings coincide with the display of these documents in the Federal Register and have been well received by providers and other interested parties. Over the next 6 months, we will further explore the use of emerging technologies and the electronic exchange of information, such as posting proposed rules and taking comments online. We will work closely with the provider, plan and practitioner communities, as well as with Congress and other parts of the executive branch, to better understand their needs as we move toward an electronic rulemaking environment.

IMPROVING PHYSICIAN AND PROVIDER EDUCATION

As part of our efforts to reinvigorate the Agency and bring a new sense of responsiveness to CMS, we are enhancing our provider education activities and opening lines of communication to our physician and provider partners. The Medicare program primarily relies on private sector contractors, who process and pay Medicare claims, to educate physicians and providers and to communicate policy changes and other helpful information to them. Working with the Medicare contractors, we have taken a number of steps to ensure the educational information that is shared with physicians and providers is consistent and unambiguous. CMS is responsible for providing policy guidelines to these private contractors, and ensuring that the contractors then perform their activities in a timely and accurate manner.

We recognize that the decentralized nature of this system has, in the past, led to inconsistency in the contractors' communications with physicians and providers, and we have recently taken a number of steps to improve the educational process. For example, we have centralized our educational efforts in our Division of Provider Education and Training, whose primary purpose is to educate and train the contractors and the provider community regarding Medicare policies. We are also providing contractors with in-person instruction and a standardized training manual for them to use in educating physicians and other providers. These programs provide consistency and ensure that our contractors speak with one voice on national issues. For example, in coordination with the Blue Cross/Blue Shield Association, we developed train-the-trainer sessions for implementing both the Hospital Outpatient and Home Health Prospective Payment System regulations, which included a satellite broadcast that was rebroadcast several times prior to the effective date of the regulation. Following these sessions, we held weekly conference calls with regional offices and fiscal intermediaries to enable us to monitor progress in implementing these changes. We are continuing to refine our training on an on-going basis by monitoring the training sessions conducted by our contractors, and we will continue to work collaboratively to find new ways of communicating with and getting feedback from physicians and providers.

Just as we are working with our contractors to improve their provider education efforts, we also are working directly with physicians and other health care providers to improve our own communications and ensure that CMS is responsive to their needs. We are providing free information, educational courses, and other services through a variety of advanced technologies. We are:

• Expanding our Medicare provider education website. We provide a variety of resources online at the Medicare Learning Network homepage, www.hcfa.gov/MedLearn.htm. MedLearn provides timely, accurate, and relevant information about Medicare coverage and payment policies, and serves as an efficient, convenient provider education tool. The MedLearn website averages over 100,000 hits per month, with the Reference Guides, Frequently Asked Questions and Computer-Based Training pages having the greatest activity. I would encourage you to take a look at the

website and share this resource with your physician and provider constituents. We want to hear feedback from them on its usefulness so we can strengthen its value.

• Providing free computer and web-based training courses. Doctors, providers, practice staff, and other interested individuals can access a growing number of web-based training courses designed to improve their understanding of Medicare. Some courses focus on important administrative and coding issues, such as how to check-in new Medicare patients or correctly complete Medicare claims forms, while others explain Medicare's coverage for home health care, women's health services, and other benefits.

• Creating a more useful Agency website. We are creating a new website architecture and tailoring it to be intuitive and useful to the physician user. We want the information to be helpful to physicians' and their staffs' office and billing needs. The same design is being used in creating a manual of "Medicare Basics" for physicians. We just completed field testing the first mock-ups for the project at the recent American Medical Association House of Delegates meeting. Once this new website is successfully implemented, we will move to organize similar web navigation tools for other Medicare providers.

In tandem with our efforts to improve physician and provider education, we are also focusing on improving the quality of our provider customer service. Last year, our Medicare contractors received 24 million telephone calls from physicians and providers, and it is imperative that the contractors provide correct and consistent answers. Now that we have toll-free answer-centers at all Medicare contractors, the need is even more pressing. We have performance standards, quality call monitoring procedures, and contractor guidelines in place to ensure that contractors know what is expected and so that we can be satisfied that the contractors are reaching our expectations. This year, for the first time, Medicare contractors' physician and provider telephone customer service operations are being reviewed against these standards and procedures separately from our review of their beneficiary customer service. During these week-long contractor performance evaluation reviews, we identify areas that need improvement and "best practices" that can be shared among our other Medicare physician and provider call centers. As a result of the reviews, performance improvement plans will be instituted when needed, and CMS staff in our Regional Offices will continue to monitor the specific contractor throughout the year.

We also want to know about the issues and misunderstandings that most affect provider satisfaction with our call centers so that we can provide our customer service representatives with the information and guidance to make a difference. To improve our responsiveness to the millions of phone calls our call centers handle each year, we are:

• Developing Call Center Profiles. Earlier this year, we visited eight of our largest Medicare contractors to collect information on their operations, their use of technology, their performance data, their most frequently asked provider questions, and their training needs. We are now collecting similar information from all of the remaining Medicare call centers via an online profile. The profiles will be completed by early August, and we will analyze them to identify additional training needs and other improvements we can make at our contractors.

• Creating a Customer Service Training Plan. Based upon the call center profiles we have gathered, we have drafted a Customer Service Training Plan to address the training needs of our Medicare customer service representatives'. This training plan will bring uniformity to the contractor training, and improve the accuracy and consistency of the information that representatives give to physicians and providers across the country. Our first training effort will focus on the widely misunderstood Correct Coding Initiative. Customer service representatives will be trained on the language and concepts of coding issues so that they can properly direct physicians and providers to the best sources of information. We plan to offer this and other training via a satellite network. We expected to provide training to all of our contractors this fall.

• Holding Telephone Customer Service Conferences. In March, we held our first National Telephone Customer Service Conference for Medicare contractor call center managers and our Central and Regional Office staff. The conference emphasized our goal of making Medicare customer service as uniform in look, feel, and quality as possible.

• Conducting Monthly Call Center Meetings. We currently hold monthly conference calls with contractor call center managers and CMS Central and Regional Office staff to identify problems, give contractors additional information, and increase the accuracy and consistency of call center service nationwide.

At the same time, we are working to develop effective standards for appropriately meeting the customer service needs of physician and provider communities we serve. We are:

• Analyzing Baseline Performance Data. Medicare call center managers were required to report data from October 1999, through May 2001 (and monthly thereafter), on a variety of performance measures. We are analyzing this data to determine contractors' relative performance and the impact of the installation of toll free lines on contractor workload and performance.

• Modernizing Customer Service Representative Workstations. To the extent resources permit, we are looking at modernizing the workstations and other tools used by our customer service representatives to ensure that they have instant access to the most current information in responding to provider inquiries.

• Monitoring Call Quality. We also formed a contractor workgroup with CMS staff to review and improve the scorecard and criteria chart that was used to measure beneficiary telephone customer service, so that it also could effectively measure the customer service of our provider customer service representatives. This new scorecard, now used by both groups, places greater emphasis on accuracy of information given in determining the final score.

IMPROVING AND EXPANDING BENEFICIARY EDUCATION

As Medicare requirements frustrate plans, physicians and providers, beneficiaries also have difficulty understanding the program's benefits and options. We know, from our research and focus groups, that far too many Medicare beneficiaries have a limited understanding of the Medicare program in general, as well as their Medigap, Medicare Select, and Medicare+Choice options. We firmly believe that we must improve and enhance its existing outreach and education efforts so beneficiaries understand their health care options. In addition, we will tailor our educational information so that it more accurately reflects the health care delivery systems and choices available in beneficiaries' local areas. We know that educating beneficiaries and providing them more information is vital to improving health care and patient outcomes.

With that goal in mind and in an effort to ensure that Medicare beneficiaries are active and informed participants in their health care decisions, we will expand and improve the existing Medicare & You educational efforts with a new advertising campaign. We will launch a multimedia campaign using television, print, and other media to reach out and share information and educational resources to all Americans who rely on Medicare, their families, and their caregivers. We are also:

• Increasing the Capacity of Medicare's Toll-Free Lines so that the new wave of callers to 1-800-MEDICARE generated by the advertising campaign receive comprehensive information about the health plan options that are available in their specific area. By October 1, 2001, the operating hours of the toll-free lines will be expanded and made available to callers 24 hours a day, 7 days a week. The information available by phone also will be significantly enhanced, so specific information about the health plan choices available to beneficiaries in their state, county, city, or town can be obtained and questions about specific options, as well as costs associated with those options, can be answered. Call center representatives will be able to help callers walk-through their health plan choices step-by-step and obtain immediate information about the choices that best meet the beneficiary's needs. For example, a caller from Mason City, Iowa, could call 1-800-MEDICARE and discuss specific Medigap options in Iowa. Likewise, a caller from Rock Hill, South Carolina, or Kingston, New Hampshire, could call and get options and costs for Medigap or Medicare+Choice alternatives in their areas. If requested, the call centers will follow-up by mailing a copy of the information discussed after the call.

• Improving Internet Access to Comparative Information and providing a new decision making tool on the Agency's award winning website, www.Medicare.gov. These enhanced electronic learning tools will allow visitors, including seniors, family members, and caregivers to compare benefits, costs, options, and provider quality information. This expanded information is similar to comparative information already available, such as Nursing Home Compare and ESRD Compare websites. With these new tools, beneficiaries will be able to narrow down by zip code the Medicare+Choice plan options that are available in their area based on characteristics that are most important to them, such as out-of-pocket costs, whether beneficiaries can go out of network, and extra benefits. They also will be able to compare the direct out-of-pocket costs between all their health insurance options and get more detailed information on the plans that most appropriately fit their needs. In addition, the Agency will provide similar State based comparative information on Medigap options and costs.

CONCLUSION

Physicians and other providers play a crucial role in caring for Medicare beneficiaries, and their concerns regarding the program's regulatory burden must be addressed. Enhancement of our communication and education efforts is essential to the success of Medicare, and we believe will ultimately reduce the level of physicians' and other providers' frustration with the Medicare program, as well as increase beneficiaries' options and satisfaction. We recognize we have a number of issues to address and improvements to make. We have already taken some critical first steps, and we are seeking input from the health care community and Congress as we work toward our goals. I appreciate having had the opportunity to discuss these issues with you today, and I am happy to answer your questions.

Chairman NUSSLE. I agree with you, I appreciate the fact that you are starting from within and asking the good people who work there for their ideas. I think that is a good idea.

Dr. Scanlon, we appreciate your being here. You have been referred to quite a bit already and your work that you have done on behalf of the General Accounting Office. We welcome you. Your testimony will be part of the record and you may summarize. Thank you.

STATEMENT OF WILLIAM J. SCANLON

Mr. SCANLON. Thank you very much, Mr. Chairman and Mr. Spratt, and members of the committee. I think the references to the two testimonies today indicate the very strong connection between what we face in the present and in the short-term and the long-term prospects for this program. In terms of my discussion with respect to the current management challenges for the agency that runs Medicare, currently called the center for Medicare and Medicaid Services, we have heard from Comptroller General Walker about the program's problematic long-term financial sustainability.

Alongside that macro view, policymakers are also examining the program's day-to-day management in an effort to identify the improvements that can help Medicare meet current 21st century needs and expectations, in particular, operating efficiently and effectively and fairly for its multiple stakeholders, beneficiaries, providers and taxpayers.

Last month's renaming of the Health Care Financing Administration is indicative of the heightened attention being placed on the agency that runs Medicare and it is for good reason. Medicare is always going to pose an enormous management challenge regardless of who runs it. Medicare is a huge program with an extremely complex mission. As Deputy Administrator King-Shaw indicated, assuring access to and paying appropriately for needed medical services for approximately 40 million beneficiaries, delivered by almost a million providers, is a challenging task. In attempting to fulfill this mission responsibly, agency actions may inevitably make it the target of parties that feel disadvantaged or harmed by some of its decisions.

Nevertheless, it is possible to take stock of HCFA's past performance and determine what lessons it holds for CMS in the future. Tasked with administering this virtually impossible complex program, HCFA earned mixed reviews. On the one hand, the agency presided over a program that is very popular with beneficiaries and the general public. It implemented payment methods that helped constrain program cost growth and ensured that Medicare contrac-

tors paid claims quickly at a little administrative cost. On the other hand, HCFA had difficulty making needed refinements to payment methods and fell short in its efforts to avoid inappropriately paying for certain claims.

In recent years, HCFA took steps to try to achieve greater success in safeguarding program dollars. However the agency now faces criticism to the provider community for a program that now, in their view, is unduly complex and has burdensome requirements. We are currently examining a number of the issues relating to program regulation, provider education and reviews of disputed claims. In the coming months we will be issuing several reports looking at CMS efforts to provide customer service to the physician community and the beneficiary population.

I can provide you today some preliminary findings from my review of the provider communications. This work was done at the request of this committee. Our findings unfortunately suggest a disappointing performance in this area. As you know, providers have voiced concern that the information they receive from carriers to explain Medicare rules and policies is often difficult to interpret, incomplete or untimely. So far, we've looked at the bulletins or newsletters that nine carriers issued since February. These bulletins are a primary mechanism for updating providers on policy changes.

Of the nine carriers reviewed, five failed to include in their bulletins important notices about billing rules that went into effect in early July. Their bulletins published the notices either after the policies had gone into effect or had not done so as of a few days ago when we last checked. We are also finding these bulletins' content can be poorly organized and difficult to use. We also—Mr. Kirk has indicated some of our results in this area—made 60 telephone calls to five carrier call centers. These are the centers that receive thousands of calls from providers every day about basic issues with respect to Medicare. We asked the call center representatives questions that providers commonly ask. It was disheartening to report, however, that as you have heard for the vast majority of those calls that we placed, the answers the phone representatives provided were either incomplete or inaccurate. The steps that Deputy King-Shaw has indicated both in his oral and written testimony——

Chairman NUSSLE. Could I just interrupt you. My understanding is that when you made those calls, you also told them that you were GAO calling. I mean this isn't just a trick phone call.

Mr. SCANLON. We said we were calling them to ask them a question and we were going to be assessing the accuracy. As I was indicating, the steps that the Deputy Administrator has outlined in his written and oral statements regarding both call centers and other provider education mechanisms, we believe, hold some promise for meaningful improvement. Our findings though, which are very current, strongly suggest how important those improvements will be, realizing the improvements will require continued diligence and attention to assure they are faithfully and consistently implemented and maintained throughout the entire program. As with other problems in Medicare's day-to-day operations, the issue of resources may to some extent account for the lackluster performance and is key to future improvements. Insufficient numbers of staff

performing certain activities and shortages in staff with appropriate skills and expertise handicap CMS.

These problems were brought into sharp focus as HCFA struggled to handle the number and complexity of Balanced Budget Act requirements as well as the program modifications that have been enacted since then.

Let me end by noting again some of the expectations we have for CMS and for Medicare. With the growth and the transformation of the health care industry, there are expectations that the agency running the Nation's largest health insurer will act as a prudent purchaser of services. There are also expectations that Medicare, despite its size, will be minimally disruptive of the health care market and minimally burdensome for beneficiaries and providers while simultaneously vigilant in protecting program dollars.

This latter centers on an expectation less often articulated that the program be operated as efficiently as possible to serve the interest of taxpayers and future generations. It is an expectation less often articulated perhaps because of the tension it creates relative to the interest of providers and beneficiaries. Today's Medicare agency, while successful in certain areas, may not be able to meet all of these expectations effectively without further congressional attention to its multiple missions and the capacity to carry them out.

Thank you very much, Mr. Chairman, and I will be happy to answer any questions you or the committee members may have.

[The prepared statement of William J. Scanlon follows:]

PREPARED STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH CARE ISSUES, U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and members of the committee, I am pleased to be here today as you discuss the long-term sustainability and the more immediate management challenges of the Medicare program. As noted in our companion statement today by the Comptroller General, the Hospital Insurance trust fund is expected to run a cash deficit in 15 years.[1] This projection, while only a partial picture of Medicare's fiscal health, nevertheless sounds the alarm for the longer term, when it is projected that, without meaningful reform, demographic and cost trends will drive Medicare to fiscally unsustainable levels. As the Congress examines large-scale reform proposals, it is also focusing on improvements needed in Medicare program management to meet current 21st century needs and expectations.

In that spirit, the Committee asked us to report on the agency that runs Medicare, newly named the Center for Medicare and Medicaid Services (CMS) and formerly known as the Health Care Financing Administration (HCFA).[2] My remarks today will focus on (1) the Medicare agency's record in carrying out selected program activities, (2) key factors affecting program management, and (3) challenges the agency faces in running a more modern Medicare program. My comments are based on our previous and ongoing work.

In brief, against a backdrop of Medicare reform proposals, the management of the Medicare program has come under close scrutiny. Our past work shows that HCFA had some notable successes as Medicare's steward but also had serious shortcomings. The agency was successful in developing payment methods that have helped contain Medicare cost growth and in paying its fee-for-service claims quickly and at low administrative cost. However, the agency's efforts to ensure that claims were paid appropriately achieved mixed results. In addition, the performance of Medicare claims administration contractors in communicating with Medicare providers was often substandard. For example, in our ongoing work for the Committee, we find shortcomings in how Medicare contractors provide information to physicians and respond to their questions.

HCFA took significant steps in recent years to address certain weak areas, such as strengthening payment safeguards, but several factors deterred improvements. The agency's responsibilities for other programs and activities and its new Medicare responsibilities emanating from recent statutory changes are substantial. Its capac-

ity to carry out these responsibilities has not kept pace. Notably, the agency faces staff shortages in both skills and numbers and is operating Medicare with archaic information technology systems that are unsuited to meet requests for basic management information within reasonable time periods. At the same time, HCFA faltered in adopting a results-based approach to agency management. In addition, constraints exist on the agency's contracting authority, limiting its use of full and open competition to choose claims administration contractors and assign administrative tasks.

Stakeholder expectations for a modern Medicare program are putting increased pressure on CMS to improve agency operations, particularly the agency's relationship with the Medicare beneficiary and provider communities. Such improvements will require efforts by the agency to implement a performance-based management approach that holds managers accountable for accomplishing program goals. However, in combination with agency actions, congressional attention also appears to be warranted to meet the challenges associated with administering Medicare in the 21st century.

BACKGROUND

The complexity of the environment in which CMS operates the Medicare program cannot be overstated. It is an agency within the Department of Health and Human Services (HHS), but has responsibilities over expenditures that are larger than those of most other Federal departments. Medicare alone ranks second only to Social Security in Federal expenditures for a single program. Medicare is expected to spend nearly $240 billion in fiscal year 2001; covers about 40 million beneficiaries; enrolls and pays claims from nearly 1 million providers and health plans; and has contractors that annually process about 900 million claims. Among numerous and wide-ranging activities associated with the Medicare program, CMS must monitor the roughly 50 claims administration contractors that pay claims and establish local medical coverage policies;[3] set tens of thousands of payment rates for Medicare-covered services from different providers, including physicians, hospitals, outpatient and nursing facilities, home health agencies, and medical equipment suppliers; and administer consumer information and beneficiary protection activities for the traditional program component and the managed care program component (Medicare+Choice plans).

The providers billing Medicare—hospitals, general and specialty physicians, and other practitioners—along with program beneficiaries and taxpayers, create a vast universe of stakeholders whose interests vary widely. Not surprisingly then, the responsibility to be fiscally prudent has made the agency that runs Medicare a lightening rod for those discontented with program policies. For example, the agency's administrative pricing of services has often been contentious, even though a viable alternative is not easily identifiable. It is impractical for the agency to rely on competition to determine prices. The reason is that when Medicare is the dominant payer for services or products, the agency cannot use market prices to determine appropriate payment amounts, because Medicare's share of payments distorts the market. Moreover, Medicare is prevented from excluding some providers to do business with others that offer better prices.[4]

In addition, Medicare's public sector status means that changing program regulations requires obtaining public input. The solicitation of public comments is necessary to ensure transparency in decisionmaking. However, the trade-off to seeking and responding to public interests is that it is generally a time-consuming process and can thwart efficient program management. For example, in the late 1990's, HCFA averaged nearly 2 years between its publication of proposed and final rules.[5]

Consensus is widespread among health policy experts regarding the growing and unrelenting nature of the Medicare agency's work. The Balanced Budget Act of 1997 (BBA) alone had a substantial impact on HCFA's workload, requiring, among other things, that the agency develop within a short time frame new payment methods for different post-acute and ambulatory services. It also required HCFA to preside over an expanded managed care component that entailed coordinating a never-before-run information campaign for millions of beneficiaries across the Nation and developing methods to adjust plan payments based partially on enrollees' health status.

The future is likely to hold new statutory responsibilities for CMS. For example, some reform proposals call for expanding Medicare's benefit package to include a prescription drug benefit. As we have previously reported, the addition of a drug benefit would entail numerous implementation challenges, including the potential for the annual claims processing workload to double to about 1.8 billion a year.

MANAGEMENT OF MEDICARE HAS BEEN A MIXED SUCCESS

Tasked with administering this highly complex program, HCFA has earned mixed reviews in managing Medicare. On one hand, the agency presided over a program that is very popular with beneficiaries and the general public. It implemented payment methods that have helped constrain program cost growth and ensured that claims were paid quickly at little administrative cost. On the other hand, HCFA had difficulty making needed refinements to payment methods. It also fell short in its efforts to ensure accurate claims payments and oversee its Medicare claims administration contractors. In recent years, HCFA took steps to achieve greater success in these areas. However, the agency now faces criticism from the provider community for, in the providers' view, a program that is unduly complex and has burdensome requirements.

MEDICARE'S NEW PAYMENT METHODS HAVE HELPED CONTAIN COST GROWTH

HCFA was successful in developing payment methods that have helped contain Medicare cost growth. Generally, over the last 2 decades, the Congress required HCFA to move Medicare away from reimbursing providers based on their costs or charges for every service provided and to use payment methods that seek to control spending by rewarding provider efficiency and discouraging excessive service use. Payment development efforts have been largely successful, but making needed refinements to payment methods remains a challenge. For example, Medicare's hospital inpatient prospective payment system (PPS), developed in the 1980's, is a method that pays providers fixed, predetermined amounts that vary according to patient need. This PPS succeeded in slowing the growth of Medicare's inpatient hospital expenditures. Medicare's fee schedule for physicians, phased in during the 1990's, redistributed payments for services based on the relative resources used by physicians to provide different types of care and has been adopted by many private insurers.

More recently, as required by the BBA, HCFA worked to develop separate prospective payment methods for post-acute care services—services provided by skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities—and for hospital outpatient departments. Prospective payment methods can help constrain the overall growth of Medicare payments. But as new payment systems affected provider revenues, HCFA often received criticism about the appropriateness and fairness of its payment rates. HCFA had mixed success in marshaling the evidence to assess the validity of these criticisms and in making appropriate refinements to these payment methods to ensure that Medicare was paying appropriately and adequately.

MEDICARE PROCESSES CLAIMS INEXPENSIVELY, BUT GREATER SCRUTINY OVER PAYMENTS NEEDED

HCFA also had success in paying most claims within mandated time frames and at little administrative cost to the taxpayer. Medicare contractors process over 90 percent of the claims electronically and pay "clean" claims[6] on average within 17 days after receipt. In contrast, commercial insurers generally take longer to pay provider claims.

Under its tight administrative budget, HCFA kept processing costs to roughly $1 to $2 per claim—as compared to the $6 to $10 or more per claim for private insurers, or the $7.50 per claim paid by TRICARE—the Department of Defense's managed health care program.[7] Costs for processing Medicare claims, however, while significantly lower than other payers, are not a straightforward indicator of success. We and others have reported that HCFA's administrative budget was too low to adequately safeguard the program. Estimates by the HHS Inspector General of payments made in error amounted to $11.9 billion in fiscal year 2000, which, in effect, raises the net cost per claim considerably. At the same time, HCFA estimated that, in fiscal year 2000, program safeguard expenditures saved the Medicare program more than $16 for each dollar spent.[8] Taken together, these findings indicate that increasing the investment in CMS' administrative functions is a cost that can ultimately save program dollars.

However, HCFA's payment safeguard activities have raised concerns among providers about the clarity of billing rules and the efforts providers must make to remain in compliance. To fulfill the program's stewardship responsibilities, claims administration contractors conduct medical reviews of claims and audits of providers whose previous billings have been questionable. These targeted reviews have been a cost-effective approach in identifying overpayments.

Providers whose claims are in dispute, however, have complained about the burden of reviews and audits and about the fairness of some specific steps the contractors follow. Their concerns about fairness may also emanate from the actions of other agencies involved in overseeing health care—such as the HHS Office of Inspector General and the Department of Justice—which, in the last several years, have become more aggressive in pursuing health care fraud and abuse.

CMS faces a difficult task in finding an appropriate balance between ensuring that Medicare pays only for services allowed by law and making it as simple as possible for providers to treat Medicare beneficiaries and bill the program. While an intensive claims review is undoubtedly vexing for the provider involved, very few providers actually undergo such reviews. In fiscal year 2000, Medicare contractors conducted complex medical claims reviews of only 3/10 of 1 percent of physicians—1,891 out of a total of more than 600,000 physicians who billed Medicare that year.[9] We are currently reviewing several aspects of the contractors' auditing and review procedures for physician claims to assess how they might be improved to better serve the program and providers.

COMMUNICATIONS WITH PROVIDERS WERE POOR

Congressional concern has recently heightened regarding the regulatory requirements that practitioners serving Medicare beneficiaries must meet. Of the several studies we have under way to examine the regulatory environment in which Medicare providers operate, one study, conducted at the request of this Committee, examines ways in which explanations of Medicare rules and other provider communications could be improved. The preliminary results of our review of several information sources from selected carriers—the contractors that process physicians' claims—indicate a disappointing performance record. In particular:

• *Bulletins.* Contractor bulletins, which are newsletters from carriers to physicians outlining changes in national and local Medicare policy, are viewed as the primary source of communication between the agency and providers. However, providers have complained that the information in these bulletins is often difficult to interpret, incomplete, and untimely. We reviewed the bulletins issued since February 2001 by nine carriers to determine, among other things, whether they included notices about four new billing procedures that were going into effect in early July 2001. The bulletins of five carriers either did not contain notices about the billing procedures until after the procedures had gone into effect or had not published this information as of mid-July. We also found that many of the bulletins contained lengthy discussions with significant technical and legalistic language.

• *Telephone call centers.* Call centers are intended to serve as another important information source for providers on a variety of matters, including clarification of Medicare's billing rules. Contractors maintain these call centers to respond to the roughly 80,000 provider inquiries made each day. We placed about 60 calls to 5 carrier call centers to obtain answers to common questions (those found on the "Frequently Asked Questions" Web pages at various carriers' web sites). For 85 percent of the calls placed, the answers that call center representatives provided were either incomplete (53 percent) or inaccurate (32 percent).

• *Web sites.* A third source of information for Medicare providers is the Internet. The agency imposes minimum requirements on carriers to maintain Web sites. Of 10 carrier Web sites we examined, 8 did not meet all of the Web site requirements, which include, among others, the inclusion of a frequently-asked-questions Web page and the capability for providers to send e-mail inquiries to customer service. These 8 also lacked the required links to both the CMS and Medicare Web sites. Many lacked user-friendly features: 7 did not have "site maps," which list the Web site's contents, and although 6 sites had search functions, only 4 worked as intended. Five sites contained outdated information.

Although these results cannot be generalized to all carriers, the carriers we reviewed serve tens of thousands of physicians and the results are consistent with some of the concerns recently expressed by physicians in the Medical Group Management Practice Association.[10]

Our study, to be issued this fall, seeks to identify the actions CMS can take to ensure that carriers improve the consistency and accuracy of their communications with providers; it will also assess the adequacy of carriers' budgets to conduct these activities.

VARIOUS CONSTRAINTS COMPLICATE EFFORTS TO MANAGE MEDICARE EFFECTIVELY

CMS faces several limitations in its efforts to manage Medicare effectively. These include divided management focus, limited capacity, lack of a performance-based

management approach, and constraints impeding the agency's ability to hold Medicare contractors accountable.

AGENCY FOCUS IS DIVIDED ACROSS MULTIPLE PROGRAMS AND RESPONSIBILITIES

CMS' management focus is divided across multiple programs and responsibilities. Despite Medicare's estimated $240-billion price tag and far-reaching public policy significance, there is no official whose sole responsibility it is to run the Medicare program. In addition to Medicare, the CMS Administrator and senior management are responsible for oversight of Medicaid and the State Children's Health Insurance Program. They also are responsible for individual and group insurance plans' compliance with standards in the Health Insurance Portability and Accountability Act of 1996 in states that have not adopted conforming legislation. Finally, they must oversee compliance with Federal quality standards for hospitals, nursing homes, home health agencies, and managed care plans that participate in Medicare and Medicaid, as well as all of the Nation's clinical laboratories. The Administrator is involved in the major decisions relating to all of these activities; therefore, time and attention that would otherwise be spent meeting the demands of the Medicare program are diverted.

A restructuring of the agency in July 1997 inadvertently furthered the diffusion of responsibility across organizational units. The intent of the reorganization was to better reflect a beneficiary-centered orientation throughout the agency by dispersing program activities across newly established centers. However, after the reorganization, many stakeholders claimed that they could no longer obtain reliable or timely information. In addition, HCFA's responsiveness was slowed by the requirement that approval was needed from several people across the agency before a decision was final.

The recent change from HCFA to CMS reflects more than a new name. It consolidates major program activities: the Center for Medicare Management will be responsible for the traditional fee-for-service program; the Center for Beneficiary Choices will administer Medicare's managed care program. We believe that this new structure is consistent with the desire to be more responsive to program stakeholders.

AGENCY CAPACITY LIMITED RELATIVE TO MULTIPLE, COMPLEX RESPONSIBILITIES

As we and others have consistently noted, the agency's capacity is limited relative to its multiple, complex responsibilities. Human capital limitations and inadequate information systems hobble the agency's ability to carry out the volume of claims administration, payment, and pricing activities demanded of it.

Staff shortages—in terms of skills and numbers—beset the agency that runs Medicare. These shortages were brought into sharp focus as HCFA struggled to handle the number and complexity of BBA requirements. When the BBA expanded the health plan options in which Medicare beneficiaries could enroll, HCFA's staff had little previous experience overseeing these diverse entities, such as preferred provider organizations, private fee-for-service plans, and medical savings accounts. Few staff had experience in dealing with the existing managed care option-health maintenance organizations. Half of HCFA's regional offices lacked managed care staff with clinical backgrounds—important in assessing quality of care issues—and few managed care staff had training or experience in data analysis—key to assessing plan performance against local and national norms and monitoring trends in plan performance over time.[11]

At the same time, CMS faces the potential loss of a significant number of staff with valuable institutional knowledge. In February 2000, the HCFA Administrator testified that more than a third of the agency's current workforce was eligible to retire within the next 5 years and that HCFA was seeking to increase "its ability to hire the right skill mix for its mission." As we and others have reported, too great a mismatch between the agency's administrative capacity and its designated mandate could have left HCFA, and now CMS, unprepared to handle Medicare's future population growth and medical technology advances.[12] To assess its needs systematically, CMS is conducting a four-phase workforce planning process that includes identifying current and future expertise and skills needed to carry out the agency's mission.[13] HCFA initiated this process using outside assistance to develop a comprehensive database documenting the agency's employee positions, skills, and functions. Once its future workforce needs are identified, CMS faces the challenge of attracting highly qualified employees with specialized skills. Due to the rapid rate of change in the health care system and CMS' expanding mission, the agency's existing staff may not possess the needed expertise.

Another constraint on agency effectiveness has been inadequate information systems for running the Medicare program. Ideally, program managers should be able

to rely on their information systems to monitor performance, develop policies for improvement, and track the effects of newly implemented policies. In reality, most of the information technology HCFA relied on was too outdated to routinely produce such management information. As a result, HCFA could not easily query its information systems to obtain prompt answers to basic management questions. Using its current systems, CMS is not in a position to report promptly to the Congress on the effects of new payment methods on beneficiaries' access to services and on the adequacy of payments to providers. It cannot expeditiously determine the status of debt owed the program due to uncollected overpayments.

STRATEGIC MANAGEMENT APPROACH LACKS PERFORMANCE COMPONENT

To encourage a greater focus on results and improve Federal management, the Congress enacted the Government Performance and Results Act of 1993 (GPRA)—a results-oriented framework that encourages improved decisionmaking, maximum performance, and strengthened accountability. Managing for results is fundamental to an agency's ability to set meaningful goals for performance, to measure performance against those goals, and to hold managers accountable for their results. As late as January 1998, we reported that HCFA lacked an approach consistent with GPRA to develop a strategic plan for its full range of program objectives. Since then, the agency developed a plan, but it did not tie global objectives to management performance.

Last month, we reported on the results of our survey of Federal managers at 28 departments and agencies on strategic management issues. The proportion of HCFA managers who reported having output, efficiency, customer service, quality, and outcome measures was significantly below that of other government managers for each of the performance measures. HCFA was the lowest-ranking agency for each measure—except for customer service, in which it ranked second from the lowest. In addition, the percentage of HCFA managers who responded that they were held accountable for results to a great or very great extent—42 percent—was significantly lower than the 63 percent reported by the rest of the government.

AGENCY HAS DIFFICULTY HOLDING CLAIMS ADMINISTRATION CONTRACTORS ACCOUNTABLE

Constraints on the agency's flexibility to contract for claims administration services have also frustrated efforts to manage Medicare effectively. Under these constraints, the agency is at a disadvantage in selecting the best performers to carry out Medicare's claims administration and customer service functions.

At Medicare's inception in the mid-1960's, the Congress provided for the government to use existing health insurers to process and pay physicians' claims and permitted professional associations of hospitals and certain other institutional providers to "nominate" their claims administration contractors on behalf of their members. At that time, the American Hospital Association nominated the national Blue Cross Association to serve as its fiscal intermediary.[14] Currently, the Association is one of Medicare's five intermediaries and serves as a prime contractor for member plans that process over 85 percent of all benefits paid by fiscal intermediaries. Under the prime contract, when one of the local Blue plans declined to renew its Medicare contract, the Association—rather than HCFA—chose the replacement contractor. This process effectively limited HCFA's flexibility to choose the contractors it considered most effective.

HCFA also considered itself constrained from contracting with non-health insurers for the various functions involved in claims administration because it did not have clear statutory authority to do so. As noted, the Congress gave HCFA specific authority to contract separately for payment safeguard activities, but for a number of years the agency has sought more general authority for "functional contracting," that is, using separate contractors to perform functions such as printing and mailing and answering beneficiary inquiries that might be handled more economically and efficiently under one or a few contracts. HCFA sought other Medicare contracting reforms, such as express authority for the agency to pay Medicare contractors on an other-than-cost basis, to provide incentives that would encourage better performance.[15]

KEY HURDLES EXIST AS AGENCY SEEKS TO MOVE FORWARD

Although the health care industry has grown and transformed significantly since Medicare's inception, neither the program nor the agency that runs it has kept pace. Nevertheless, CMS is expected to make Medicare a prudent purchaser of services using private sector techniques and improve its customer relations.

AGENCY FACES CHALLENGES IN ADOPTING MODERN MANAGEMENT STRATEGIES

Private insurance has evolved over the last 40 years and employs management techniques designed to improve the quality and efficiency of services purchased. In a recent study, an expert panel convened by the National Academy of Social Insurance (NASI) suggested that Medicare test private insurers' practices designed to improve the quality and efficiency of care and determine whether these practices could be adapted for Medicare.[16] Private insurers have taken steps to influence utilization and patterns of service delivery through efforts such as beneficiary education, preferred provider networks, and coordination of services. They are able to undertake these efforts, in part, because they have wide latitude in how they run their businesses. In contrast, Federal statutory requirements and the basic obligation to be publicly accountable have hampered agency efforts to incorporate private sector innovations.

Medicare's efforts to encourage use of preferred providers is a case in point. The Medicare statute generally allows any qualified provider to participate in the program. This is significant in light of HCFA's experiment related to coronary artery bypass graft surgery in which certain hospitals—identified as those with the best outcomes for these surgeries—were designated to receive bundled payments for hospitals and physicians delivering certain expensive procedures.[17] The experiment cut program costs by 10 percent for the 10,000 coronary artery bypass surgeries performed and saved money for beneficiaries through reduced co-insurance payments. HCFA began a similar experiment at selected acute-care hospitals, which involves bundling payments for hospital, physician, and other health care professionals' services provided during a beneficiary's hospital stay for selected cardiovascular and orthopedic procedures. However, more wide-scale Medicare implementation of such hospital and physician partnership arrangements may be difficult. Providers have raised concerns about government promotion of certain providers at the expense of others, thus creating a barrier to this and other types of preferred provider arrangements.

Efforts to facilitate disease management provide another example of the potential limitations of adapting private sector management strategies to Medicare. HCFA was able to implement broad-based education efforts to encourage the use of Medicare-covered preventive services, but the agency could be deterred in approaches targeting individual beneficiaries most likely to need the help. For example, the agency has overseen the dissemination of more than 23,000 posters with tear-off sheets that beneficiaries can hand to physicians to facilitate discussions of colon cancer screening that otherwise might be avoided because of unfamiliar terms and sensitive issues. It has also been involved in a multifaceted effort to increase flu vaccinations and mammography use. However, the agency may be less able to undertake the more targeted approaches of some private insurers, such as mailing reminders to identified enrollees about the need to obtain a certain service. Because targeting information would require using personal medical information from claims data, CMS could encounter opposition from those who would perceive such identification to be government intrusion. Providers might also object to a government insurance program advocating certain medical services for their patients.

In its study, NASI concluded that these and other innovations could have potential value for Medicare but would need to be tested to determine their effects as well as how they might be adapted to reflect the uniqueness of Medicare as both a public program and the largest single purchaser of health care. In addition, CMS would likely need new statutory authority to broadly implement many of the innovations identified in the NASI study.

AGENCY SEEKS TO MEET EXPECTATIONS FOR IMPROVED CUSTOMER SERVICE FOR PROVIDERS

Congressional concern has heightened recently regarding the regulatory burden on the practitioners that serve Medicare beneficiaries. In his testimony before the Senate Committee on Finance, the Secretary of HHS emphasized the importance of communication between CMS and providers, stating, "When physicians call us * * * we need to respond quickly, thoroughly and accurately."[18] Under the spotlight held by both the Congress and the administration, CMS is expected to improve its customer service to the provider community.

Concern about regulatory burden is not limited to providers in Medicare's traditional fee-for-service program. Policymakers are also concerned about the regulatory burden on health plans that participate in the Medicare+Choice program. During each of the last 3 years, substantial numbers of health plans reduced the geographic areas they served or terminated their Medicare participation altogether. Cumulatively, these withdrawals affected more than 1.6 million beneficiaries who either had

to return to the fee-for-service program or switch to a different health plan. Industry representatives have attributed the withdrawals, in part, to Medicare+Choice requirements that they characterize as overly burdensome.[19]

HCFA took steps to address plans' regulatory concerns by modifying some requirements or delaying their implementation. It also launched an initiative designed to help the agency better understand plans' concerns, assess them, and recommend appropriate regulatory changes. At the request of the House Ways and Means Subcommittee on Health, we are evaluating Medicare+Choice requirements. Our study will compare Medicare+Choice requirements with the requirements of private accrediting organizations and those of the Office of Personnel Management for plans that participate in the Federal Employees Health Benefits Program. The study's objective is to document differences in these sets of requirements and determine whether these differences are necessary because of the unique nature of the Medicare program and the individuals it serves.

AGENCY STRIVES TO IMPROVE BENEFICIARY EDUCATION

CMS is also expected to improve communications with beneficiaries, particularly as the information pertains to Medicare+Choice health plan options. The agency has made significant progress in this regard but continues to face challenges in meeting the sometimes divergent needs of plans and beneficiaries.

As required by the BBA, HCFA began a new National Medicare Education Program (NMEP).[20] For 3 years the agency has worked to educate beneficiaries and improve their access to Medicare information. It added summary health plan information to the Medicare handbook and increased the frequency of its distribution from every few years to each year. It also established a telephone help line and an Internet Web site with comparative information on health plans, Medigap policies, and nursing homes and sponsored local education programs.

Beginning this fall, it will become more important for beneficiaries to be aware that Medicare+Choice health plan alternatives to the traditional fee-for-service program may be available in their area and to understand each option and its implications. As required by the BBA, Medicare will now have an annual open enrollment period each November when beneficiaries must select either the fee-for-service program or a specific Medicare+Choice plan for the following calendar year. Beneficiaries will have strictly limited opportunities for changing their selection outside of the open enrollment period, a provision known as "lock-in."

CMS recently announced that it would fund a $35 million advertising campaign this fall to help beneficiaries learn about Medicare's new features—such as the proposed discount prescription drug card program, coverage for preventive services and medical screening examinations, and the annual enrollment and lock-in provisions—and provide general information about Medicare+Choice plans and the availability of Medicare's Web site and telephone help line. The agency will also extend the operating hours of the help line and add an interactive feature to the Web site designed to help beneficiaries select the Medicare option that best fits their preferences.

CMS has made other decisions about the fall information campaign that illustrate the sometimes difficult trade-off between accommodating plans and serving beneficiaries. To encourage health plan participation in the Medicare+Choice program, CMS has allowed plans additional time to prepare their 2002 benefit proposals. This extension will hamper the ability of CMS and health plans to disseminate information before the BBA-established November open enrollment period. CMS will not, for example, include any information about specific health plans in the annual handbook mailed to Medicare households.[21] To reduce the potentially adverse effects of an abbreviated fall information campaign, the agency will allow health plans to distribute marketing materials with proposed benefit package information marked "pending Federal approval." CMS will also extend the open enrollment period through the end of December.

CONCLUDING OBSERVATIONS

Medicare is a popular program that millions of Americans depend on to cover their essential health needs. However, the management of the program is not always responsive to beneficiary, provider, and taxpayer expectations. CMS, while making improvements in certain areas, may not be able to meet these expectations effectively without further congressional attention to the agency's multiple missions, limited capacity, and constraints on program flexibility. The agency will also need to do its part by implementing a performance-based management approach that holds managers accountable for accomplishing program goals. These efforts will be

critical in preparing the agency to meet the management challenges of administering a growing program and implementing future Medicare reforms.

ENDNOTES

1. Medicare: New Spending Estimates Underscore Need for Reform (GAO-01-1010T, July 25, 2001).

2. Our statement will refer to "HCFA" where our findings apply to the organizational structure and operations associated with that name.

3. Most medical policies for determining whether claims for services provided are medically necessary and covered by Medicare are established locally by the claims administration contractor that serves the specific geographic area involved.

4. Statutory constraints on limiting the providers from which Medicare beneficiaries may obtain medical services or products have resulted in the program including all qualified providers who want to participate.

5. This finding reflects the last half of 1997 and the first half of 1998 and an average of 631 days.

6. These are claims that have been filled out properly and whose processing has not been stopped by any of the systems' computerized edits. According to HCFA data on claims processed in fiscal year 1999, about 81 percent of Medicare claims were processed and paid as clean claims.

7. Much of the cost difference appears attributable to differences in program design and processing requirements, but we and others believe that TRICARE has opportunities to reduce this administrative cost. See Defense Health Care: Opportunities to Reduce TRICARE Claims Processing and Other Costs (GAO/T-HEHS-00-138, June 22, 2000).

8. As part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Congress created the Medicare Integrity Program (MIP), which gave HCFA a stable source of funding for program safeguard activities. In fiscal year 2000, HCFA used its MIP funding to support a wide range of anti-fraud-and-abuse efforts, including provider and managed care organization audits and targeted medical reviews of claims.

9. Complex medical reviews are in-depth reviews of claims by clinically trained staff based on examination of medical records. In contrast, routine medical reviews may be carried out by nonclinical staff and do not involve review of patient records.

10. These concerns are contained in a June 2001 letter from Medical Group Management Practice Association to the House Budget Committee staff.

11. HHS Office of the Inspector General, Medicare's Oversight of Managed Care: Implications for Regional Staffing (OEI-01-96-00191, April 1998).

12. Gail Wilensky and others, "Crisis Facing HCFA & Millions of Americans," Health Affairs, Vol. 18, No. 1 (Jan./Feb. 1999).

13. HCFA's workforce planning efforts were in line with our guidance in Human Capital: A Self-Assessment Checklist for Agency Leaders (GAO/GGD-99-179, Sept. 1999).

14. Intermediaries primarily review and pay claims from hospitals and other institutional providers, while carriers review and pay claims from physicians and other outpatient providers.

15. For a discussion of this issue, see Chapter 3 in Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity (GAO/HEHS-99-115, July 14, 1999).

16. From a Generation Behind to a Generation Ahead: Transforming Traditional Medicare, Final Report of the Study Panel on Fee-for-Service Medicare, National Academy of Social Insurance (Washington, D.C.: January 1998).

17. A number of studies prior to this experiment have found that hospitals with the greatest volume of these procedures generally had better outcomes, as measured by mortality and complications.

18. Statement Before the Senate Committee on Finance, Hearing on Medicare Governance: Perspectives on the Centers for Medicare and Medicaid Services (formerly HCFA) (June 19, 2001).

19. Industry representatives have also cited Medicare's payment rates as a cause of the withdrawals. They believe that Medicare payments are inadequate for the services health plans provide. However, our studies have estimated that such payments exceed what Medicare would have spent if beneficiaries enrolled in health plans instead received services through the traditional fee-for-service program. See Medicare+Choice: Payments Exceed Cost of Fee-for-Service Benefits, Adding Billions to Spending (GAO/HEHS-00-161, Aug. 23, 2000).

20. We have reviewed the agency's NMEP activities to date and will soon release a report discussing our findings.

21. As a result of these decisions, the Secretary of HHS is now the subject of a lawsuit that claims he did not have the authority to change the benefit filing date and that the BBA requires an annual mailing containing comparative health plan information.

Chairman NUSSLE. Thank you very much for your testimony. And as I said, when Congressman Pallone arrives, we will take his testimony. In the meantime I am sure a number of us have questions. I was amazed at a meeting I was at very recently, some health care providers in my district came and we were on the subject of overall health care reform and modernization and prescription drugs and kind of along the line of where Mr. Bentsen and Mr. McDermott were going and other members on the committee were going. While these providers were very hopeful about the kind of reforms that were coming down the pike, I think the one thing they told us, please don't hurt us anymore. You know, it is easy to beat up on HCFA and CMS and say it is all your fault. What are you doing down there? Eighty-five percent of the phone calls are no good. We could go into that diatribe very easily, but Congress is the one that passes the law, determines the benefits and makes a lot of the rules and tries to shove it down through the system and it doesn't seem to work.

I was amazed because they brought to me—one constituent in particular brought to my attention something I thought that was fascinating. On a home health visit—and basically what it was just so you have the context—I am not supposed to use the name, but what it was was the beneficiary's paperwork requirement for single home health episode.

The reason there was the home health episode was because the woman in question had a hip replacement and was 74 years old. I reviewed the paperwork and, interestingly enough, she was doing fine. Hip replacement went well, as many—most do in our Nation. It has become a very routine procedure. I looked through the paperwork and the only thing I can find that is interesting—and I don't mean to suggest that it is not interesting. We do take our health care and the quality of our health care for granted these days, but the one thing that is interesting from the paperwork that I read was that she was in pain that morning during the visit because she had sat too long she thought the day before in one of her chairs that she thought was too hard and should have been over on the couch using the pillow that she was given to help manage some of the circulations. She had some slight discomfort. She didn't want to admit it was pain; it was just discomforting.

Well, you would think that the visiting nurse could report back and say, you know, I went to visit Mary Johnson—that is not her name—but I went to visit her. She was fine. Hip replacement seems to be going well. No infection. Everything is fine, which is what this says. She did have some pain because she needed to be instructed on how to use her pillow. But everything is fine.

Well, let me just show you what they had to turn in when it comes to paperwork and everything else. What I will do is ask one of these guys—I want you to see what is involved because this is amazing to me. This is the first sheet. And it is going to keep going. Now this is what she had to do—this is the nurse now—had to fill this out for one single 60-day home health episode. And I invite you—anybody to read it. All I can find in there, and I am very

serious, she is in pain. Not a lot of pain, but it is—it is not even double-sided. It almost goes to the door. We didn't quite get a long enough one to get to the door. Actually, this is the one they provided for us. I don't know what we need to do. I am not suggesting that this is the fault of any one, two people, agencies involved, but our nurses are frustrated because this is health care for them. Our patients are frustrated and our beneficiaries are frustrated because someone has to sit through the examination, and that is usually them. Our health care providers are frustrated because they know that I am probably the only person outside that hospital that has read this. And trust me when I say I didn't really read it as much as I skimmed it, because no one would want to read that. I have got much more reading that I need to do. But there is no way in my estimation that we will ever get our hands around the cost and the long-term obligations of this program if we can't do something as simple as that, and that is figure out a way to put on one single sheet of paper the visit that says she is OK. Her hip is OK. No infection. Everything is fine. I will see her in another 60 days and I told her to use her pillow.

I would be happy for you to comment on that. And the other thing, Mr. King-Shaw, I would invite you to comment on—I know you had a chance to review the concerns about the bulletins, the call centers and the web sites, at least to begin with, to give you a chance to respond to those issues because I know you are concerned about them. I am not suggesting by any of this that you are going to defend any of this because I know both from your background as well as your mission that that is what you are here to fix.

So I am just interested in what process you are going through in order to get your arms around some of these details that GAO has provided today, and if you have any expectation that you can provide to us and when we will might be able to see some improvements that not only are practicable improvements with regard to the quality and delivery of health care, but also the financial long-term stability for our Medicare program for our country.

Mr. KING-SHAW. Sure. In 10 words or less, I would say first on the issue of performance, we are relooking at many of our forms, enrollment forms, documentation forms. We have a number of them that are being designed for simplicity and are going through a clearance process. So I think you will begin to see new forms replacing these old forms that will be simpler, more user friendly that will contain the right information. That is a definitive process that has begun already, and I think you will begin to see increasingly forms coming out in a more user-friendly format.

We also have a longer term initiative, something called our physicians regulatory initiative team. That is a team that focuses working with physicians about some of the practical ways that we can simplify, remove, correct and streamline the day-to-day regulations that are gumming up the works, such as this. And that has been extremely effective already in just coming to the less lofty, more specific everyday type of regulations, rules, interpretations and requirements that don't add to quality of care or facilitate good medicine. And that is a national effort.

One other thing I will say is, there are a number of provider groups that are coming together that now have an open door and open access with CMS to talk about these things in coming up with strategies to change them. In those discussions we are learning that some of those requirements are not ours at all, but it is what the in-house counsel is telling providers that they must do to defend against a lawsuit. It is what CMS expects or we can't really understand the CMS rules, so do all these things to cover you no matter how they interpret it because it changes all the time. Or the Department of Justice will interpret this rule this way, OIG will interpret it this way, so you do all these things to cover the waterfront.

So what we are trying to do is separate those things that we at CMS can do immediately and then work with our partners to have a common understanding of what these rules mean and clearly communicate what the rules are so the world doesn't have to guess all the time and do this defensive strategy.

On the contractor performance, I will spend a great deal of time on those. Part of that is driven by the fact that we don't have great flexibility in contracting. The actual performance of our contractors is very unrelated to our ability to change the contract or find a better performer or move business to those who have more capabilities. These are not outcome-based contracts. These are cost contracts. And so it is not that we can go out and replace one with a better performer of a different type.

So what we have begun to put together is a reform package that includes contractor reform. And when Congress will feel comfortable with our ability to manage under more flexible contracts, more outcome driven contracts, I think you will see the performance of contractors change. Internally, we have to get better at specifying the expectations that we have of our contractors. We spend a great deal of time looking at the fraud and abuse, financial integrity issues and the beneficiary issues. We need to put more time into looking at how contractors interact with providers and be more specific and have higher expectations of the way they interact with providers. So we will be having specific standards for Internet and call centers and our own service observe programs where we listen in on telephones and conversations so we can keep track of the quality of the answers, not just how quickly they answer the phone, but the accurateness of the information given in that conversation, all those things that the rest of the world does that we have to begin to do.

Chairman NUSSLE. Mr. Spratt.

Mr. SPRATT. HCFA has gotten a lot of flack. Every Member of Congress can testify to that. Any one at least who has spoken to a local hospital administrator's group or physician's group. But in truth, HCFA largely manages this program through fiscal intermediaries, does it not?

Mr. KING-SHAW. That is correct.

Mr. SPRATT. To what extent would you, on the back of the envelope, estimate that the work is actually contracted out, management work; 80 percent, 90 percent?

Mr. KING-SHAW. Up to the mid-90's, if you really look at where the work is done. I can get the exact figures. But the vast majority

of the program administration is contracted out either to the health plan side, private plans or the intermediaries that pay the claims and do the reviews.

Mr. SPRATT. How many different fiscal intermediaries are there across the country?

Mr. KING-SHAW. I think in the 50's now. Fifty of them. We go through a process of consolidating where we can to the stronger providers. But there are a number of, I guess, fiscal intermediaries for the part A side, a different number for the part B side and medical equipment beyond that. There is a whole other network of things beyond that do such things as program safety and program integrity.

Mr. SPRATT. One of the complaints that I have received is that different fiscal intermediaries read the regs differently themselves and they have different rules for PSAs and what is an approved drug for a particular illness. Is this a chronic and serious problem?

Mr. KING-SHAW. It is a problem. The system was designed by Congress to be that, however. I mean when the Nation established the Medicare program, it was to contract for the services through a number of Blues organizations, each relying on much of their own decision making for medical management decisions. And so, a lot of what we have today is a reflection of the original intent of the mid-60's that has been outmoded. It has not kept up with the medical practices or services that are financed and administered today.

As far as the coverage decisions, a number of coverage decisions are delegated to the carriers for local application, and so there are inconsistencies. The alternative to that would be for Medicare essentially to determine coverage in every respect and manage centrally a program that was on paper designed to be a regional one. And that is a rethinking of the direction of the Medicare program, and Congress would have to direct us to do that.

Mr. SPRATT. Dr. Scanlon, do you find this arrangement creates confusion, problems with the span of control of management?

Mr. SCANLON. We find that on a repeated basis that it does create confusion. The contractors, while fulfilling to some extent the original intent of not interfering with the local practice of medicine, they put their own interpretations on those instructions at times, creating confusion for providers. Since intermediaries deal with hospitals and other part A providers, and there may be multiple intermediaries operating in a single community, it is possible for different providers to be hearing very different things about what the program allows or does not allow. So it is something that we think that centralization of some sort, either oversight or more explicit operation from a centralized focus, would have real benefits in terms of making the program operate more effectively.

Mr. SPRATT. Would you still have to contract out services though?

Mr. SCANLON. Without creating a much larger agency of Federal employees, one needs to contract for these services. And there are real gains from contracting for these services because what we are talking about are things that private sector parallels to in terms of processing information. Think of Visa and MasterCard in terms of being able to process transactions. Medicare transactions are much more complicated, but they still are transactions that can be

processed electronically. Today more than 80 percent of them are. So we want to buy that expertise instead of trying to rebuild it, I think, within the agency.

Mr. SPRATT. Mr. King-Shaw.

Mr. KING-SHAW. I don't think the Medicare program can adapt and develop and grow and achieve viability without contracting out many of its functions, its administrative functions included. I think the critical issue is the nature of those contracts, the leverage we have in those contracts, the ability to negotiate new and different contracts with, in some cases, new and different providers. That I think is the pivotal piece toward achieving the objective we all share.

Mr. SPRATT. I represent one of the larger contractors, one of the Blues that does a lot of work for you, and their complaint to me is that they have underfunded themselves. And Dr. Scanlon touched on that in his testimony. They say the costs per claim administered speaks for itself. It is dramatically low compared to private carriers, administration of their own programs, compared to TRICARE, for goodness sake, which is 7½ dollars a claim, I think. So they say they are rendering good stewardship over the program, but every year comes back to us and I guess to the administration too, because if you don't drive the point home adequately, we cut them and cut the money back for them and they are stretched to the point where quality is affected.

Do you share that view?

Mr. KING-SHAW. There are some contractors that clearly are under financial pressure and that the costs attributed to their operations is a very tight squeeze for them. I don't know if that is true for all contractors. But I do think we need to look at the overall financing of the program and the allocation of resources. It is not that these contractors can recoup an investment in a profit or a surplus situation. These are cost contracts. So there is very little incentive for a good provider to plow more money into their operations in hopes of getting a return and therefore conducting the kind of continuous quality improvement that their private sector peers are.

Mr. SPRATT. Dr. Scanlon, we passed Medicare+Choice several years ago. You note in your testimony that HCFA wasn't really ready for it in terms of personnel trained to deal with managed care. They were woefully inadequate. And we had testimony this morning and I have heard the GAO say it on other occasions, that Medicare+Choice, which was supposed to save money, has actually cost us money because of adverse selection.

Mr. SCANLON. That is right, and we have looked at this extensively and issued two reports last year to update some earlier work that we had done. What we did find was there was continued adverse selection and that the program was costing Medicare more than if those people remained in fee for service. In addition to looking at the health status of the individuals that were enrolling in Medicare+Choice, if you looked at what the Medicare+Choice plans were offering beneficiaries, you had a sense that there may be some slack here. On average, plans were offering about 60 dollars worth of benefits because of the statutory requirement that they not make any more profit on a Medicare beneficiary than they do

on some other enrollee. On top of that, they were offering about 60 more dollars worth of benefits, seemingly as loss leaders, to attract beneficiaries to their plan.

This I think has been a clear indication that we may be paying plans too much in terms of delivering the Medicare benefit package—though there is a paradox, which is we have had so many plans leaving the program. And they have said that they cannot afford to remain in Medicare, and they have indicated that strongly by leaving the program.

The issue is do we value Medicare+Choice and the type of managed care that it delivers enough to pay that additional price to attract plans in the program. I think that is a decision that we need to provide—gather better information and provide that to the Congress so the Congress can make that choice.

Mr. SPRATT. One final question, Mr. King-Shaw. One of the topics covered in Mr. Scanlon's testimony was making beneficiaries understand the program better, their recourses, what the benefits are. You recently introduced a new benefit which some of my constituents are calling about to find out what it means, and that is the discount pharmacy card.

What role has HCFA played in this area and what does this card mean?

Mr. KING-SHAW. Well, the card essentially means that beneficiaries can join one of the buying groups, if you will, once these cards are approved—I will get to that in a moment—and with that card, have the benefit of group pricing discounts on a number of drugs. These drugs will be actually supplied by the prescription drug benefit managers, and CMS is responsible for endorsing those cards that meet standards for service, will communicate the benefits and that kind of thing.

It is not a benefit in the sense that this is a new benefit change that Congress would have to adopt. In fact, we are endorsing cards that have the capability to pool beneficiaries, and as a result of that volume buying power, negotiate superior, as in lower, prices for beneficiaries so that their out-of-pocket costs for——

Mr. SPRATT. Will this be negotiated with the pharmaceutical companies or with the drug retailers, or both, and will they be preferred providers?

Mr. KING-SHAW. It is our anticipation that the PBN's that sponsor these cards will negotiate their discounts with their drug companies. There are other types of cards out there that we are not attached to, that we are not endorsing, that achieve their discounts by negotiating a different price with the retailer, the pharmacist or the distributor.

These programs are intended to result in a reduction in the pricing of drugs with the manufacturer of the drugs, not the outlet.

Mr. SPRATT. So before this is an operable card, we have got some negotiating to do.

And do you have benefit managers hired and lined up to do this work yet?

Mr. KING-SHAW. Not yet. We have issued a request for those interested to participate in this program, to document their capabilities, you know, their discounts, their program, etcetera. We at CMS will select, based on known and published criteria, those card pro-

grams that we will endorse. The actual management of this program will fall to a consortium that these card programs, the PBMs, will fund.

Part of their agreement to take part in these programs is that each one of these cards will contribute financially to a consortium that will be responsible for making sure that every senior who has a card is only in a one-card program, therefore, they are not double counting; that each one of these card programs supplies the necessary information so that seniors can choose which card program they want, understanding that different card programs may have different levels of discount on the same drug.

And so, ultimately, a consortium will be responsible for managing the program. CMS will support in some way as an equal partner in this consortium, but this will not be a CMS-driven or federally funded program, if you will.

Mr. SPRATT. When is it ultimately coming? Is it a year off before you can really have a card that you can take to the local pharmacy?

Mr. KING-SHAW. We anticipate that elders will have cards in their hands by January of 2002, if not sometime in December. We are hoping to have the cards selected sometime in September or October. We know that the consortium will be up so that there is an infrastructure, you know, so folks can begin making choices in that November-December time frame.

Mr. SPRATT. Is this just a Medicare beneficiary?

Mr. KING-SHAW. That is all we are focusing right now is the Medicare beneficiary.

Chairman NUSSLE. Mr. Kirk.

Mr. KIRK. Dr. Scanlon, I find your report excellent. Again, the management problems that you highlighted that five out of nine bulletins were wrong, 85 percent of the telephone calls wrong, eight out of ten web sites incomplete. You had some interesting claims cost data that CMS showed, that it cost $2 to process a claim; and you reported that the industry started at $6 a claim.

And something that now concerns me, TRICARE, the military's HMO, was $7 a claim. So it makes me think about what CMS is doing that industry and TRICARE should be doing.

But later on in your report, you indicate that CMS has losses from bad claims management totaling $12 billion. If you add that back into their claims management cost, it is $14 a claim, which makes me then think, what is the industry doing right that CMS is doing wrong?

Further, in your report, you mentioned, in the Government Performance and Results Act, that CMS was the lowest ranking of 28 Federal agencies for every measure except customer service and it is second from the bottom on customer service. Given your work and what you have done, can you contrast any of these performance measures with the Federal Employee Health Plan and the kind of claims administration numbers or performance that it might show?

Mr. SCANLON. Well, of course, the Federal Employees Health Benefits Program operates exclusively through private sector health plans. So some of the information we provide about the pri-

vate sector health plans will actually be plans that are participating in FEHBP, so that is their type of experience.

And I do think in terms of making the comparison about how much is lost by CMS in terms of inappropriate payments, we would also have to adjust the numbers on the private side. There has not been the same kind of effort on the private side to measure their losses to inappropriate payments. So their numbers are going to go up as well.

We have come to the conclusion that the old adage of penny wise and pound foolish may apply here, that there are sort of more efforts that are being exercised on the private side and, potentially, in TRICARE to try and reduce the losses to inappropriate payments, to try to provide better customer services to both beneficiaries and physicians. I think that that is a key to us—that we need to think about if we are dissatisfied with losses for inappropriate payments and customer service—perhaps we need to make the investment to make those things better.

When we make that investment, we ought to make sure that we have a plan to accomplish that. And then we hold CMS accountable to that plan.

The report that you indicated, where CMS ranked low relative to other government agencies really was an issue of accountability. Do managers have performance targets that they feel have been clearly articulated and to which they feel they are held accountable? And the answer was, fewer CMS managers felt that than virtually any other Federal agency.

Mr. KIRK. I would note from your report, $1 in additional administrative compliance would be $16 in savings. So you rapidly see how CMS, if it was at the claims level of industry or TRICARE, closes the gap.

Mr. SCANLON. We may encounter some diminishing returns there, but we certainly would make some considerable savings.

Mr. KIRK. On the case management issue, your report says that CMS would be unable to take wide advantage of case management, which is where the employer-provided health care is going. Because targeted information would require using personal medical information from claims data, CMS would encounter opposition and could not do it. That is a question for the both of you.

Do you see this as something for Congress to address so we could move CMS in the same direction that other health care providers are going to ensure that patients are complying with their doctors' directions, and therefore, their health status is improving and costs are lower?

Mr. SCANLON. It could be beneficial to consider having some type of case management service to be part of Medicare in which the beneficiaries and providers could avail themselves of that service; and there would be a fraction of the beneficiary population with chronic needs that would then benefit from that. The program would benefit, as you indicated, from the better management of services—in particular, pharmaceuticals, which can be problematic in terms of interactions, lack of compliance, etcetera.

The thing we are concerned about, or feel there will be concerns about, is the way the private health plans have approached this. They have been more proactive. They have identified, through their

claims information, who it is that has a chronic illness within their beneficiary population; and they have gone and contacted them and said, we think you need case management, or maybe even more aggressively, said, we want to case manage your services.

The idea of a government program potentially doing that, we think potentially can be problematic; and it is an issue about the perception of the government analyzing your health data and making a decision about what you need.

As Mr. King-Shaw indicated, when we started Medicare, Congress gave clear instructions we were not to interfere with the practice of medicine. So this would be a very bold step, one that would depart from that.

Mr. KIRK. Mr. King-Shaw, do you think that having patients comply with their doctors' direction is a very "bold" step?

Mr. KING-SHAW. No. I think Medicare is bringing up the rear in case management. I believe very firmly in case management and the more robust disease management applications. I think the fusion, if you will, of clinical best practice and administrative support and financial structures that really support compliance and early detection and maintenance and behavioral change, is an essential part of moving the health care delivery system in the Medicare program forward. I see nothing inconsistent about Federal or government programs participating in disease management and case management or State programs.

Some of the leaders in disease management and case management have been the States, notably Florida, Virginia and others. So I am actually quite excited about seeing Medicare embrace disease management and case management. There is legislation that passed Congress last year that enabled some demonstration projects in disease management for Medicare that would include prescription drug therapy. And I think we should all look forward to good outcomes there.

Quickly, on the note of claims costs, to my knowledge, I don't believe that TRICARE does calculate error rates for their claims. And so I don't know if we have that second number, what to add back in for TRICARE and the others to compare it to the number that you ran for us. If we do have error rates for the other Federal programs, either Federal employees or TRICARE, and we add those back in, then we would get a picture of where CMS ranks according to the other two. But to my knowledge, they do not calculate that.

Mr. KIRK. I defer to Dr. McDermott, who recommends we all eat our broccoli.

Chairman NUSSLE. Dr. McDermott, with that introduction.

Mr. MCDERMOTT. Mr. Chairman, I want to begin by saying I am sorry I can't stay for the rest of the hearing because you will have some good examples of people who are actually out in the field doing this. Dr. Kaplan is from Seattle and represents the managers of these programs, and I think can give you some really concrete examples.

But I would like to ask a question. Mr. Scanlon, as I understand this process, we pass the laws and then HCFA writes the rules and regulations applicable to the laws to implement the laws that we have passed. And administrators, whether they are intermediaries

or whoever, they simply follow the rules that have come down through that process; is that correct?

Mr. SCANLON. Largely correct. There is in the law as well as in the regulations some room for local variations and in some provisions of the statute.

Mr. MCDERMOTT. So the paper trail that Mr. Nussle just showed here really came from us. When we are looking for the enemy, we are the ones that set that in motion; is that correct?

Mr. SCANLON. You didn't create the form, but essentially you created the demand for what the form was intended to do, which was appropriately pay for the service as well as use it for quality-of-care purposes.

Dr. MCDERMOTT. Let me turn to one of the areas that I think has been an area of great concern, and that is the sole issue of fraud. Several years ago, we decided we were going to save a whole bunch of money with fraud. And we went after people and we said, this is fraud because you said you did this, but there is no documentation; and so now everybody is documenting and documenting and documenting and documenting and documenting. And it seems to me that an enormous amount of what you saw in that paper trail or what was on that paper trail was probably documentation of what had gone on. Would that be your guess?

Mr. SCANLON. Well, in that particular instance, I think we have a very unusual circumstance because there has been a requirement—I mean, a lot of the documentation you are talking about is documentation that Mr. King-Shaw indicated that providers decide they need to do in order to be able to justify their claim. But in the case of home health, there has been specified a very detailed assessment instrument for each beneficiary who is entering into the home health episode.

A part of the reason is, the Medicare program is going to pay for that episode between $1,000 and $6,000. And the issue is, do we know why we are paying for—for an episode that is expensive and can we have expectations as to how much care an individual is going to get?

The second reason that that assessment was created is that there were concerns created a number of years ago about the quality of care being provided by some home health agencies. We had tremendous proliferation in terms of their numbers. We were concerned with the fact that the certification standards were very loose, and it was very easy to become an agency.

So one of the things that the assessment is intended to do is to try and spotlight the quality problems so that certification efforts can be more in focus. But in other circumstances, I mean, there are not similar kinds of requirements and there necessarily should be those kinds of requirements.

Mr. MCDERMOTT. Are you saying—if I understand what you just said—you are saying that doctors are doing all this documentation now, simply in order to have a paper trail to deal with a fraud investigator who comes thundering into their offices and goes into their records looking for fraud about whether or not a particular thing has been undercoded, overcoded or whatever. The doctors are doing that. There are no regulations that they are following that specify—I give you this example.

If I charge for a long-term case—excuse me, a full examination—I have got to look at every one of the systems in the body and document everything from the skin all the way through to whatever; and if I don't do that, the presumption is that it is fraudulent that I said I did a full examination, it is all written down, then have I done a fraudulent examination.

Now, the doctor decides, I am not going to be considered fraudulent, so I am going to put all this stuff in because I don't want these guys hanging around beating me up.

You saying this is a figment of their imagination?

Mr. SCANLON. No. I am saying there is a general requirement for the documentation that if you provide a service and bill Medicare for that service that you would be able to demonstrate that you have provided that service; and, therefore, there is a documentation requirement that is associated with that.

Mr. MCDERMOTT. Where does the fraud investigator get his or her list of things to look and say, it isn't there, so that is fraudulent? Where do they get their scheme by which they look at these issues?

Mr. SCANLON. The area that I think you are pinpointing is the area of evaluation and management services, which is what we used to know as "office visits" and "hospital visits" for physicians. Over the past 10 years, determining what is the appropriate level those visits or those evaluation management services has become much more complex because we have gone from a system where we used to pay for each visit in terms of the amount of time and the specialty that was providing the service to a system where we have tried to pay for the same service, the same amount of money, which means there is not a specialty distinction.

There has been a joint activity on the part of HCFA and the American Medical Association to try and develop mechanisms as to which ones demonstrate what the service involves. And this is exactly the kind of thing you talked about—their having to say, I have dealt with every body system, I have done the following, I have considered the following, and therefore this is a visit of this complexity.

And physicians tell us all the time—and I sincerely believe them—that it, in some ways, has changed the practice of medicine. In addition to doing things that you would routinely do, you now have to write them down, and that is something that we have concerns about. And I think in terms of CMS's review of documentation requirements, that this is an area where there should be some strong focus.

Mr. MCDERMOTT. Do—I mean, I would like to see if you have written recommendations about how to change that system. Nobody wants fraud. I don't know any doctor who is going to say, we want to be allowed to be fraudulent. But the question is, how do you do that in the least wasteful way or the most efficient way.

If you have suggestions that you can give us, to the committee or to the Ways and Means Committee—I mean, both of us are dealing with this issue—I would be appreciative.

Mr. SCANLON. I wish we did. We have been struggling with that issue ourselves. Because given the concept that we want to pay a single price for a specific type of service and the fact that there are

so many things that happen in a medical encounter that we have to try and sort those into homogenous groups, that it is an awful task; and we have not found the simple solution to this or even a way to simplify the current method.

Mr. MCDERMOTT. Mr. Chairman, could I have one more question?

Chairman NUSSLE. Yes.

Mr. MCDERMOTT. My whole medical career has been spent in Seattle, where we had group health and we had managed care since the day the century turned, started—it is 1945 or 1946. And the idea that HMOs, managed care, was somehow going to save money as—I have great difficulty understanding how, if we take the average cost of a patient in Medicare and we pay that to an HMO and then we say, well, you are more efficient, so you get 95 percent, why isn't that enough for them to get by?

Why do they keep coming in and saying we need more and more and more?

Mr. SCANLON. I think it is partly the issue that on top of the medical costs that they are going to incur, they have added some management costs in terms of really trying to scrutinize care and decide what is appropriate; and this does cost money.

In terms of I think what is happening now with respect to the increased growth in health care costs, what we are seeing is that managed care in the first round was able to get significant discounts from providers. The era of those discounts has probably ended in many areas, and therefore, their costs are rising as providers are demanding essentially to be paid higher rates. So I think that is part of what drives some of the need for additional funding.

This last year, in terms of the Medicare+Choice plans, withdrawal from Medicare was very different from what preceded it. What preceded it was, the plans that were generally not doing as well in an area, left that area; it was plans that had recently joined an area and didn't do well initially in marketing themselves, and they decided to leave.

This year, we had much more widespread withdrawal of plans. But it would also coincide with the cost pressures that were coming more generally in the health care market, and I think that was a factor in terms of what we saw.

Mr. MCDERMOTT. So the bottom line then is that managed care is no better than the other system?

Mr. SCANLON. We mentioned that Medicare and HCFA and the Congress, in fact, in terms of the legislation specifying how the program was going to pay for services, really has been effective in controlling costs, or at least the cost of individual services. Medicare was a leader—I mean, starting with the hospital prospective payment system in 1983, that was probably the first time a large payer got aggressive about trying to say we are not going to pay so much for a unit of service. And so that is what the managed care plans are competing against, Medicare's leverage and Medicare's record in trying to control prices.

Mr. MCDERMOTT. Thank you, Mr. Chairman, for your indulgence.

Chairman NUSSLE. Mr. Holt.

Mr. HOLT. Thank you, Mr. Chairman. I would like to raise a somewhat more specific issue for Mr. King-Shaw and Mr. Scanlon,

but it is a problem that I think involves a larger issue touching on Medicare reform and costs. And I would like to work with you in trying to come up with a solution to this in the future; it may require legislation.

The problem is simply this: Current Medicare policy pays for injectable forms of drugs in the case of kidney dialysis patients, but not the exact same supplements in their cheaper oral form. And I know that the agency is looking at many issues related to Medicare and end-stage renal disease. My colleagues, Representative Ryan and Representative Baldwin, here on the committee have also paid some attention to this.

The legislative prohibition preventing Medicare from covering self-administered prescription drugs for patients undergoing kidney dialysis may be costing our taxpayers well over $100 million a year.

Now, I realize in the scheme of the numbers that we have been talking about today, that may not seem like so much, but it is not chicken feed either. Current Federal policy requires Medicare to treat drugs with the same therapeutic benefits in fundamentally different ways.

There really is a logical gap here, when for drugs injected into a patient by a physician, Medicare can pay most of the cost of the drug, but if the drug is taken orally Medicare is prohibited from paying for it. And so this is costly to the patient and to the taxpayer.

And, you know, I think that right now the vast majority of patients who undergo hemodialysis and who almost all also deal with calcium deficiencies or potential calcium deficiencies, have to take one of two injectable drugs. But the oral drug has been found to be as safe and as effective as the injectable drugs in most cases.

Well, I don't need to go into the detail of it. I think you get the gist of the problem.

Medicare policy now may view the injectable drugs and the oral version as different substances. But doctors assure me—and I, as a scientist, am convinced that they are not—that they have the same active ingredient and studies show that the two substances are equally safe and effective; and it just seems irrational that Medicare covers one form of the drug, the more expensive form, and not the other.

Again, this may require legislation to fix, but I would very much like to work with you to find—well, the real cost of this disparity and possible solutions to it.

Mr. KING-SHAW. Briefly, we can, of course—we will at the staff level, respond to you with the exact cost differentials that you are looking for, to the extent that we can.

I think the larger issue points to what the President and Administrator Tom Scully have been saying, Medicare needs to be reformed and needs to modernized and made current according to current medical practice. And so we could either interact with you on this specific issue—but it is symptomatic of a very much larger issue, and that is keeping Medicare policy up with the times and with technology. Distinctions that used to exist don't anymore, and we haven't adjusted our policies in the congressional statutory framework in which we live to reflect those changes.

And we will be happy to have all those discussions with you.

Mr. HOLT. Well, I hope that we can deal with some of these particular individual problems and perhaps some other individual problems rather than delaying them while we wait for a wholesale reform of the program, because this really has to do with the quality of care that patients are getting now, the convenience of their medication; and as I said, you know, something on the order of $100 million is serious money. So I look forward to working with you on that.

Thank you.

[Recess.]

Chairman NUSSLE. Thank you, Mr. Holt. I want to thank our panelists for their testimony and for their information on this. We look forward—I think you can tell from the attitude here, we look forward to working with you in trying to come up with solutions. As I said when I opened this with all the paperwork, I am certainly not blaming or suggesting that it is all one entity's responsibility or fault. We have got the same responsibility at this end of the street, and we will work with you to figure that out, and I know we have a number of issues.

So we look forward to your suggestions on what Congress can do to help make sure this program works. So thank you very much.

At this point in the record, I would like to ask unanimous consent to insert Congressman Pallone's testimony. He has been patient with us. We have not been able to accommodate his schedule and visa versa and so we will—I will ask unanimous consent to put his statement in the record at this point.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

INTRODUCTION

Mr. Chairman, Members of the Committee, thank you for extending me the opportunity to speak before your Committee today.

In 1965, our Nation made a promise to the American people that they would have health insurance when they turned 65 and that they would not be denied medical care simply because they could not afford it. This promise has held up remarkably. Medicare has been a reliable program that has provided important services to our seniors since 1965 and every time I talk to seniors in my district, I know that these services are making a meaningful difference in people's lives.

The Medicare program currently serves about 40 million beneficiaries and the program ensures that seniors and the disabled are able to live longer and richer, more productive lives. However, we are at a crossroads. Medicare needs to be improved and there are several directions in which we can move forward. The issue of regulatory burden needs to be addressed, along with important improvements such as adding a prescription drug benefit that would cover all seniors who want it, increasing protections to ensure that Medicare remains affordable for all beneficiaries and extending the life of the Medicare program so that it will be there for the baby boomers and beyond.

REGULATORY BURDEN PLACED ON PROVIDERS

As the largest health insurer in the U.S., Medicare is a vast and extremely complex program. The program works with literally hundreds of thousands of physicians and thousands of hospitals, suppliers, and other types of providers. It is not surprising that CMS processes nearly 1 billion Medicare fee-for-service claims per year.

Given the complexities of this program and the extent of its statutes and regulations, it is no doubt that providers are bogged down with regulatory burdens and endless paperwork. The program should be run efficiently and most importantly,

should allow legitimate providers to practice medicine and serve their patients most effectively. I hear from providers on a daily basis and the message I hear is that being forced to sit behind stacks of paperwork day after day is unacceptable and a hindrance to providing necessary care to seniors.

There have been improvements to Medicare that have helped clarify the processes for receiving appropriate reimbursements. In addition, Medicare's payment error rate was reduced by about 45 percent between 1996 and 1998. This is a positive step in the right direction; however, Congress must remain committed to providing an avenue for further cutting payment error rates. This will ensure that providers are receiving appropriate payments for their services and inadvertently, that beneficiaries will be receiving proper care.

PRESCRIPTION DRUGS

The lack of an affordable prescription drug benefit is without question the biggest problem with the Medicare program today. The problem cannot be corrected piecemeal by simply devising a plan to cover the poorest seniors. A comprehensive, affordable drug benefit should be available to all seniors regardless of income. 50 percent of Medicare beneficiaries without drug coverage are middle class seniors.

Instead of providing a meaningful benefit through Medicare, it seems as though President Bush and the Republican Leadership are preparing to either provide drug coverage to only low-income beneficiaries or to provide drug coverage that relies on private drug-only insurance. Neither of these plans will allow beneficiaries to receive a comprehensive, affordable, guaranteed benefit and in fact, these plans will nurture the price discrimination beneficiaries face when purchasing pharmaceuticals.

In terms of privatizing Medicare, a proposal that relies on a voucher-type system under which private health plans compete with one another, as well as with the traditional Medicare program, raises several problems. Most importantly, private health plans have already abandoned hundreds of thousands of seniors from Medicare+Choice plans and yet, we are hearing of proposals that rely on private health plans for Medicare restructuring. In the last 2 years alone, 106 plans dropped out of Medicare+Choice altogether, 111 plans reduced their service areas and any other plans increased premiums and reduced benefits.

In addition, the drug discount card program proposed by the President is not an interim solution to providing a comprehensive prescription drug benefit. Many companies already provide these cards at little or no expense, drug manufacturing companies are not held accountable while it places the entire burden of any possible savings on hometown pharmacies and it does not require Medicare to pay even a portion of the Medicare recipients' cost of prescription drugs. When talking about reforming or modernizing Medicare, a drug discount card or privatization is not helpful to seniors, rather, a comprehensive benefit under the Medicare program is what people want.

SOLVENCY AND COSTS TO SENIORS

At a time when seniors can barely afford their prescription drugs, it is important in this discussion of Medicare reform to ensure that health costs to seniors for basic services do not increase. There are proposals that claim that a combined benefit package would be easier to administer the Medicare program and that the private market no longer separates hospital and insurance policies, so why should the Medicare program? More importantly, the argument is made that redefining solvency by measuring the combined status of trust funds will make Medicare's financial status more clear. The President's budget has already endorsed this policy because it would help lawmakers reduce the amount of general revenues allocated to the Medicare program.

Merging Parts A and B of the Medicare program may contribute to a rise in cost of the Medicare program, which would be financially detrimental to seniors nationwide. If both Parts A and B of Medicare are combined, it seems clear that most seniors would face a higher deductible. The deductible for Part A is $776 but only 15% of seniors utilize Part A services in a given year. The deductible for Part B is $100 and an overwhelming 85% of seniors use Part B services in a given year.

Combining these two parts and finding a deductible that falls in between the Part A and B amounts will surely present a majority of beneficiaries with a significantly higher deductible—which means that most seniors would have to pay more out-of-pocket before their Medicare benefits kick in. It is important to keep in mind that this higher deductible would add to the average of about $3,000 out-of-pocket that seniors pay for health services, including prescription drugs.

This would only be exacerbated by the fact that most seniors would see a rise in premiums for their supplemental insurance policies. Many of these policies pay for Part A and Part B coinsurance and deductibles—and if these costs increase from merging the two parts, it is likely that employers and beneficiaries will both have to make up the difference in cost.

Asking beneficiaries to pay more out of pocket than they already do is unacceptable and an aspect of Medicare reform that is certainly detrimental is merging the Hospital Insurance and Supplemental Insurance Trust Funds, thereby increasing the cost of Medicare before we even add a prescription drug benefit.

CONCLUSION

Thank you again, Mr. Chairman and Members of the Budget Committee, for allowing me to testify on Medicare reform. I hope you will keep in mind that along with easing regulatory burdens for providers, we must protect the integrity of the Medicare program, secure solvency of the Medicare trust fund, keep costs down for seniors, and provide a comprehensive prescription drug benefit under the Medicare program.

Thank you.

Chairman NUSSLE. I invite the third panel to come forward at this time, and we will take a 2-minute recess while they are getting situated.

[recess.]

Chairman NUSSLE. The third and final panel that we have on Medicare and the need to reform, first of all, Dr. Gary Kaplan is the chairman of the board of directors for the Medical Group Management Association; Dr. James Bean, who is a neurosurgeon from Lexington, Kentucky; and also Marilyn Moon, who is—Dr. Marilyn Moon, who is senior fellow from the Urban Institute.

We welcome all three of you here today. Your entire testimony will be made part of the testimony and during the time you have, we would ask you to summarize what you have come here to tell us today.

STATEMENTS OF DR. GARY S. KAPLAN, CHAIRMAN, BOARD OF DIRECTORS, MEDICAL GROUP MANAGEMENT ASSOCIATION; DR. JAMES R. BEAN, NEUROSURGICAL ASSOCIATES; AND MARILYN MOON, SENIOR FELLOW, URBAN INSTITUTE

Chairman NUSSLE. And we will begin with you, Dr. Kaplan. I think I got it wrong earlier, I may have said you were the one who was from Kentucky. You are from Seattle and it is Dr. Bean who is from Kentucky. My apologies, welcome.

STATEMENT OF DR. GARY KAPLAN

Dr. KAPLAN. My name is Dr. Gary Kaplan. I'm the Chair of the board of directors for the Medical Group Management Association. On behalf of MGMA, I want to thank the chairman and the entire committee for convening today's hearing.

The hearings held by this committee during the 106th Congress focused the attention of lawmakers and the new administration on numerous administrative barriers affecting the delivery of care to Medicare beneficiaries. This foresight resulted in a GAO study measuring Medicare's administrative complexities in which MGMA members participated.

As Dr. Scanlon testified earlier, the GAO confirmed the difficulties which providers have in obtaining accurate, timely and consistent information from Medicare's carriers. MGMA is the Nation's oldest and largest medical group practice organization, represent-

ing more than 18,000 administrators working in organizations in which over 176,000 physicians practice medicine.

In addition to my leadership position with MGMA, I am a practicing internal medicine physician and the chairman and CEO of the Virginia Mason Medical Center, an integrated, nonprofit medical center with 400 physicians, a 330-bed hospital and over 5,000 employees in western Washington State.

Too much time today is spent by practice personnel dealing with the innumerable and continually changing Federal rules and regulations governing coding, documentation, billing, referrals, coverage, credentialing and reassignment of physician billing rights, all at the expense of patient care. Complex regulations such as these create a gold mine for attorneys and consultants, but an administrative land mine for group practice physicians and administrators.

My comments today focus on the administrative ills of the Medicare program and how these problems lead to government and medical group practice management inefficiencies, unnecessarily diverting limited resources away from patient care. While MGMA agrees with both the current and previous administrations that additional CMS funding is warranted, the efficiencies resulting from improving CMS's organization, communication and responsiveness should vastly improve the system without creating additional costs.

I will begin my discussion with two examples or problems we have personally experienced with the administration of the Medicare program. My first example involves a recent routine audit conducted earlier this year by our Medicare intermediary. In certain circumstances, Medicare requires providers to determine whether Medicare or another payer will be the primary source of payment for a service provided. The fiscal intermediaries are responsible for occasional routine reviews to assure that a provider is collecting the proper documentation from hospital patients. A glaring example of a good thing taken to an inefficient extreme, the intermediary requested copies of specific documents for each service billed to Medicare for one entire month. The intermediary indicated that it would select at random only 60 encounters from the entire collection of documents for use in its audit.

We informed the intermediary's representative that the request would involve many thousands of patient visits and claims and would require a dramatic time-consuming effort to produce. We were informed that these were the audit guidelines and that we were to produce the documents as requested.

This example highlights the administrative overkill which practices must deal with on a routine basis. Over the next 5 weeks, Virginia Mason personnel, from the director of operations to temporary staff we hired specifically for this audit, put in 1,019 hours and used 12 boxes of copier paper to collect, print and copy the requested documents. By the day of the audit, 33 boxes containing information for 17,000 patients and 43,000 claims had been collected. As promised, upon arrival of the auditor, he promptly chose 60 claims at random from the roomful of boxes. The auditor reviewed the documents quickly and then left having spent 2½ hours on site.

In the end, the auditor turned up no problems with the claims. Our staff, however, was left to refile or destroy over 60,000 documents.

My second example involves the lack of coherence in Medicare rule presentations to providers. Medicare requires that physicians provide patients with an advance beneficiary notice, an ABN, of non-covered services. This well-intentioned requirement was designed to give the patient better knowledge of their coverage and potential out-of-pocket costs before accepting a particular service.

However, the situations which providers must provide an ABN are not easily understood, and they vary from code to code. Further, these rules are not set out in a central location in CMS rules or carrier guidelines, but are instead strewn throughout various manuals and guidebooks.

Recognizing the daunting task these rules posed to physicians and staff wanting to provide ABNs at the appropriate time, Virginia Mason was forced to accumulate and organize the rules for ourselves into an internal manual. And, after over 300 person-hours of long and largely duplicative work, the manual was a remarkable 188 pages in length. This was for only one specific rule. Because each page must be reviewed for accuracy whenever any governing authority releases a revised or new policy, the work of updating the manual is never over. Needless to say, the task of creating usable Medicare manuals should not fall on providers whose time should be spent caring for patients.

While I have outlined more detailed solutions in my written testimony, let me quickly turn to some basic steps the Congress can take to cure the administrative ills of the program. Congress should, number one, require HHS to create and distribute a user-friendly manual that contains all the information necessary for Medicare compliance.

Number two, it should require HHS to publish and notify providers of policy and operational changes on four specific dates during the year, rather than the current haphazard manner.

And number three, finally, require HHS to annually conduct a review of and report to Congress on the sources and complexities in the program as is required of the I.R.S. In the Restructuring and Reform Act of 1998.

On behalf of the Medical Group Management Association, thank you for the opportunity to share our thoughts with you today. MGMA realizes that both CMS and its contractors are called upon to accomplish an extremely difficult and complex task. However, much more needs to be done to improve the administration of Medicare to eliminate waste and innefficiency. We should never lose focus on why the program was developed in the first place to provide quality patient care. Thank you very much.

[The prepared statement of Dr. Kaplan follows:]

PREPARED STATEMENT OF GARY S. KAPLAN, M.D., CMPE, CHAIRMAN, BOARD OF DIRECTORS, MEDICAL GROUP MANAGEMENT ASSOCIATION

Good morning. My name is Gary Kaplan, M.D. I am the chair of the Board of the Medical Group Management Association. On behalf of MGMA, I would like to thank the chairman, the ranking member, and the entire committee for convening today's hearing. I also would like to extend our gratitude to the Committee for its leader-

ship in pursuing information on the costs and administrative burdens that the Medicare program imposes on both providers and the government.

The hearings held by this Committee during the 106th Congress focused the attention of Members of Congress and the new administration on numerous administrative barriers affecting the delivery of care to Medicare beneficiaries. The foresight of this Committee resulted in a GAO study measuring Medicare's paperwork burdens in which MGMA members participated. This study and other efforts by the Committee led to policy makers actively discussing solutions to these problems.

MGMA is the Nation's oldest and largest medical group practice organization representing more than 18,000 administrators working in organizations in which over 176,000 physicians practice medicine. MGMA's membership reflects the full diversity of physician organizational structures today. Our members work on a daily basis ensuring their practices provide the best care possible to Medicare beneficiaries, while at the same time navigating their medical groups through a sea of complex, and often contradictory rules, regulations, and policy memoranda. As a result, MGMA is uniquely familiar with the administrative requirements of Medicare's regulations.

In addition to my leadership position with MGMA, I am a practicing internist and the Chairman and CEO of the Virginia Mason Medical Center, an integrated, nonprofit medical center with 400 physicians and over 5000 employees. These health care professionals serve together in a multi-specialty group practice in Western Washington State with 13 clinic sites and a 330-bed hospital. Virginia Mason hosts a thriving graduate medical education program, a prominent research center, and serves as a referral center for the entire Pacific Northwest.

As the Chair and CEO of Virginia Mason I am charged with many diverse responsibilities. The physicians in our practice rely on me and my administrative staff to guide them through the remarkable complexities of today's health care delivery system. They require our business "know how" to allow them focus on the importance of their day-to-day clinical interaction with their patients. As the leader of an organization that honors strong commitment to quality and integrity, I am responsible for ensuring that each of our physicians, administrators and staff understand and abide by the rules that govern our work. Too much time is spent by practice personnel dealing with the innumerable and continually changing Federal rules and regulations governing coding, documentation, billing, physician referral rules, Local Medicare Review Policies, physician credentialing and the assignment and reassignment of patient and physician billing rights, at the expense of patient care.

I have experienced, on a personal level, the growing frustration of most managers and administrators with the ever-increasing mass and complexity of Federal regulations. The varied level of communication, organization, and responsiveness from CMS and its contractors makes efforts to understand, much less comply with these rules, all the more difficult. Regulations such as the recently released privacy rule create a gold mine for attorneys and consultants, but an administrative landmine for our medical group practices.

My comments today will focus on the administrative ills of the Medicare program and how these problems lead to Federal Government and medical group practice management inefficiencies, unnecessarily diverting limited resources away from patient care. While MGMA agrees with both the current and previous administrations that additional CMS funding is warranted, the efficiencies resulting from improving CMS's organization, communication and responsiveness will vastly improve the system without creating additional costs.

Examples of Breakdowns:

Let me begin with actual examples of burdens and breakdowns in the administration of Medicare. I will begin my discussion with two examples of problems we have personally had with the administration of the Medicare program, followed by those experienced by my colleagues nationwide. Through these examples, I hope to give you some insight into medical group practice management and the constant battles we wage with inefficiencies in the Medicare system. As you continue your oversight of this program and develop recommendations for improvements, I urge you to personally visit a group practice in your district and discuss Medicare's complexities with the practice administrator.

INFLEXIBLE REQUIREMENTS AND SENSELESS USE OF RESOURCES

In certain circumstances Medicare requires providers to determine whether Medicare or another payer will be the primary source of payment for the services provided. The fiscal intermediaries (FI) are responsible for occasional routine reviews to assure that a provider is collecting the proper documentation from hospital patients.

Our FI notified us of a routine audit earlier this year. However, in a glaring example of a good thing taken to an inefficient extreme, the FI requested copies of specific documents for each service billed to Medicare for one entire month. The FI indicated that they would select, at random, only 60 encounters from the entire collection documents for use in their audit.

We informed the FI representative that the request would involve many thousands of patient visits and claims, and would require a dramatic, time-consuming effort to produce. This work seemed neither necessary nor cost efficient given their ultimate need for just 60 items. We were informed that these were the audit guidelines, and that we were to produce the documents as requested.

Over the next 5 weeks, Virginia Mason personnel from the Director of Operations to temporary staff (hired specifically for this audit) put in 1,019 hours and used twelve boxes of copier paper to collect, print, and copy the requested documents. By the day of the audit, 33 boxes containing information for 17,000 patients and 43,000 claims had been collected.

As promised, upon arrival the auditor quickly chose documents representing 60 claims at random from the roomful of boxes. The auditor reviewed the documents quickly then left, having spent 2.5 hours on site. We were left with over 60,000 documents to refile or destroy.

We understand that the auditor was simply following established audit guidelines. We believe, however, that there are more effective means of addressing Medicare's well-intentioned audit concerns.

COMPLEXITY AND LACK OF COHERENCE IN RULE PRESENTATION

Medicare requires that physicians provide patients with an Advance Beneficiary Notice (ABN) of non-covered services. This well-intentioned requirement was designed to give a patient better knowledge of their coverage and potential out of pocket costs before accepting a particular service.

However, the situations in which providers must provide an ABN are not easily understood, varying from code to code. Further, these rules are not set out in a central location in CMS rules or carrier guidelines, but are instead strewn through out various manuals and guidebooks.

Recognizing the daunting task these rules posed to physicians and staff wanting to provide ABNs at the appropriate times, Virginia Mason was forced to accumulate and organize the rules itself into an internal manual. After over 300 person-hours of long and largely duplicative work, the manual was a remarkable 188 pages in length. Because each page must be reviewed for accuracy whenever any governing authority releases a revised or new policy, the work of updating the manual is never done.

We appreciate and applaud CMS' recent efforts to design a simpler, more patient-friendly model ABN form. However, we now ask for similar help in formulating simple, provider-friendly rules that govern when to use them.

INCONSISTENCIES IN COVERAGE RULES WITHOUT NOTICE

We also encounter inconsistencies between local coverage rules and a carrier's implementation of those rules. Often policy changes are made without notice to the provider. As an example, Local Medicare Review Policies (LMRPs) for the state of Washington do not designate coverage limitations for spirometry services (measurements of lung volume and air flow). However, our detailed review of Medicare denials discovered that these claims were routinely being denied as non-covered services.

After a time consuming investigation, we found that while Washington State LMRPs do not limit coverage for spirometry, other states within our Part B Carrier's area do. The Carrier had simply adopted these other states' standards and applied them to its entire area, effectively trumping our local LMRPs. This decision was made without creation of a formal policy and notice to providers. If it were not for our detailed denial review and extensive investigation these claims would have continued to be denied for completely unknown reasons.

As a result of our efforts in this area we understand that a carrier-wide sprirometry policy is now being drafted, and we applaud the carrier's responsiveness to our concerns. However, we feel providers should not shoulder the burden of discovering such inconsistencies through denial reports.

CARRIER CHANGES TO CODING GUIDELINES WITHOUT NOTICE OR EXPLANATION

Under current coding guidelines (Current Procedural Terminology-4, or CPT-4), if a physician performs two related procedures for a patient on the same day, one of the procedures will be paid at only 50 percent of the regular allowed amount, since the costs involved are presumed to be lower for the second procedure. In billing lan-

guage, the guidelines require a −51 modifier to be attached to the second procedure code.

The CPT manuals clearly indicate certain exceptions to this rule, however, including diagnostic cardiac catheter procedures. Thus, under CPT guidelines no modifier must be attached for these procedures, and full payment is indicated.

However, despite this CPT guideline, our Carrier has determined—without prior explanation or notice—that the above rule will indeed apply to diagnostic cardiac catheter procedures in its coverage area. It therefore processes the claims accordingly, and imposes the 50 percent payment reduction. The carefully constructed and extensively used CPT manuals should not be arbitrarily reversed through Carrier discretion without a clear explanation and well published notice to those affected. And again, providers should not need to discover these rules through their after-the-fact denial reports.

CARRIER SYSTEMS ISSUES

Our Medicare carrier credentials physicians for both their specialty and any appropriate subspecialties. A physician may therefore be credentialed not only for internal medicine, but also for a subspecialty in pulmonology. However, the carrier's claims processing system is able to receive only one of these data fields through its interface with the credentialing system, essentially ignoring any information on subspecialty.

Under Medicare rules, only one physician visit from the same specialty may be charged in a single day. In complex cases, however, patients will frequently be seen by both an internal medicine physician who is coordinating the patients' care, and a second internist with a subspecialty in pulmonology. Because of the carrier's system limitations, the subspecialty of the second physician is ignored, and the pulmonologist's claim is simply denied as unnecessary.

We recognize that this is a systems problem and are grateful for the carrier's intentions to upgrade its claims processing systems to address the issue. However, we spend tremendous time and effort in addressing these particular denials each day. Practices should not be forced to bear the burdens of correcting problems caused by inadequate carrier systems.

LACK OF COMMUNICATION FROM CMS TO CONTRACTORS AND IN TURN TO PROVIDERS AS WELL AS INEFFECTIVE ROUTINE SYSTEM CHANGES

On October 30, 2000, CMS sent carriers an electronic quarterly update of the Correct Coding Initiative (CCI). The CCI contains more than 121,000 pairs of codes that cannot be billed on the same claim to Medicare. Each quarter it is "updated" to add or delete various code combinations. Under CCI, claims are scanned and scrubbed electronically for "disallowed" code pairs, which are then automatically denied.

Without any prior notice to providers or carriers as to its contents, the October version of the CCI disallowed the billing of sixty-six different evaluation and management (E&M) codes when performed on the same day as over 800 procedures. Providers were never told that as a result of this revision, in order to bill for a physician visit or other E&M code on the same day as any one of the 800+ procedures, they were required to use the "-25" billing "modifier" or annotation. Implementation of the CCI update resulted in thousands of claim denials. However, many carriers did not become aware of the cause of the denials until the provider community notified them of the problem. The carriers simply implemented the electronic edits received from CMS without knowing how the action would affect their claims processing operation. To further exacerbate the situation, carriers denied claims that actually used the correct modifier. In a memo sent out to the provider community outlining the problem in late January, CMS admitted that, "Unfortunately, a number of carrier processing systems do not recognize the -25 modifier" with certain codes.

While parts of the October update were rescinded on February 8, 2001, the original implementation occurred at tremendous cost to both providers and carriers. Not only did this communication breakdown between CMS, the carriers and ultimately providers, result in physician practices around the country having to resubmit thousands of denied claims billed from October 30, 2000 to February 8, 2001, it undermined the trust and credibility necessary to preserve a good working relationship between practices and carriers. As a side note, members of the Committee might be interested to know that if my, or any other practice, as a participating provider in the Medicare program, desires access to a copy of the quarterly CCI update, it is not accessible online and only available through NTIS Products (CMS's authorized distributor) for an annual $300, four issue, subscription fee or $85 per single update, plus shipping and handling.

INCONSISTENCIES BETWEEN CMS MANUALS AND MEDICARE STATUTE

Frequently, the relationship between providers, carriers and CMS is strained due to the ambiguous and, at times, incorrect information in the Medicare Carriers Manual itself. The Medicare Carriers Manual contains CMS's instructions to its carriers on how to administer the program. The following technical, yet illustrative example shines light on one such example of this problem. Under 1861(s)(3) of the Social Security Act, "diagnostic X-rays, diagnostic laboratory services and other diagnostic tests" are covered separately by Medicare from physician services. However, section 2070 of the Medicare Carriers Manual states "for diagnostic X-ray services and other diagnostic tests, payment may be made only if the services are furnished by a physician or incident-to a physician service (which requires direct-supervision by the ordering physician). This carrier manual provision is contrary to the Social Security Act Section 1861(s)(3) coverage provisions for these services and has caused numerous interpretive problems between providers and carriers concerning the appropriate level of physician involvement and supervision.

LACK OF NOTICE TO MEDICAL GROUP PRACTICES OF CMS' INTENTIONS TO CHANGE BILLING AND PAYMENT RULES

Medical group practices trying to play by the rules are often blindsided by policies implemented without notice to or input from the effected parties. For example, in May 1998, CMS issued Transmittal No. 1606, which drastically changed the billing rules for allergy immunotherapy. The new rule, which amended the definition of "dose," meant that physicians could, in most situations, only bill for half as many doses as they had actually prepared. CMS's interpretation went against longstanding practice and was inconsistent with the CPT Code definition and the American Medical Association's CPT guidance. This change took effect without prior notice to the physician community. The effect of the adjustment reduced reimbursement in half for allergy immunotherapy billed under CPT Code 95165. It took the affected physician practices and their representatives two and a half years to get CMS to see the error of its policy. The policy was finally rescinded effective January 1, 2001 with the implementation of the 2001 Medicare physician fee schedule.

CARRIER MISTAKES UNRESOLVED

While some Medicare carriers and intermediaries are quite good, others are plagued with problems that may take months to resolve. Prompt action by Medicare carriers and intermediaries to resolve their own mistakes is critical to the Medicare program. The following example from a colleague of mine illustrates this point.

In September 1999, a large multi-site practice organized as a rural health clinic, located in Michigan, received Medicare checks totaling $1,260,184.84, far in excess of their billed charges. The management service organization (MSO) that does billing for these clinics, immediately notified United Government Services, LLC, (UGS) their Medicare fiscal intermediary, about this overpayment and were told that the intermediary would get back to them on the issue. The MSO asked if they could return the checks but UGS instructed them to retain the payment until the problem had been sorted out. The MSO contacted the intermediary once a week for a month before they were told that there had been a problem with UGS' processing system that had produced this overpayment. UGS' Detroit office instructed the MSO to retain the money and that it would be recouped via withholdings from future payments. The MSO informed the Medicare intermediary that recouping the money in this way would take a minimum of 5 years. UGS' response was that the same type of erroneous payments had been sent to a number of other physicians. These incorrect payments were direct deposited to the physicians' accounts and as a result the physicians were drawing interest on the money. The clinic's payment had been sent in the form of a paper check and UGS felt that the clinic should have the same opportunity to draw interest on these incorrectly paid funds. The clinic did not want to cash the payments in the first place.

To resolve this problem the MSO spent an extensive amount of time attempting to obtain corrected explanations of benefits so that they could ascertain what the correct payment should have been and then return the difference. This process took months and involved a great deal of back and forth between the MSO and the Medicare FI. Finally, on September 21, 2000, more than a year after the initial overpayment by the fiscal intermediary, these problems appeared resolved and the overpayment was returned to UGS the Medicare intermediary.

The problem, however, was not resolved at this point. During the year in which the clinic and its MSO billing entity had been attempting to sort out the problem, UGS, the intermediary had, as they originally proposed, been withholding Medicare

payments due to the clinic to make up for their original erroneous overpayment. When the MSO returned the overpayment, UGS continued to withhold payment for current claims. Efforts by the clinic to resolve this problem were unsuccessful until the HCFA Regional Office was contacted to assist the clinic in its dealings with the intermediary.

LACK OF CMS OVERSIGHT AND ENFORCEMENT OF ITS REQUIREMENTS OVER CONTRACTORS

The Medicare Carriers Manual, under Section 1030.1 (enrollment instructions to the carriers) states "absent extenuating circumstances, [a carrier must] process an application for non-certified providers within 45 calendar days of receipt of the application. For certified providers, process the application within 30 calendar days, absent extenuating circumstances. If you need to review the application for incomplete or missing information, the processing time stops. Complete the review of the application and annotate what information is missing prior to returning application (emphasis added)." In reality, this is not what occurs. If a carrier finds an error in the application, it sends it back to the provider at the first instance of an error taking place. Once corrected by the provider, the application goes to the "back of the line" to begin the process anew. Due to the complexity of the 34-page application and instructions, this resubmission process sometimes may occur several times before a physician is enrolled in the program. If a review was actually done in a complete manner as per the Medicare Carrier Manual, and the information annotated in its entirety, before being returned to the provider for correction, the process would work much more efficiently. Instead, it now may take up to 6 months to enroll a physician in the program. During this time period, a physician can examine and treat Medicare patients, but all claims resulting from those services cannot be submitted for payment until the certification process is complete. Situations like this are particularly aggravating given that the physician enrollment process has no statutory foundation in the Medicare Act and CMS has spent years trying to develop regulations governing the enrollment process.

LACK OF PROVIDER EDUCATION TOOLS AND RECENT ACTION IN THE WRONG DIRECTION

Education of providers concerning how to comply with rules and regulations is fundamental to the efficient administration of the Medicare program. I know of few, if any, physician practice managers who also happen to be lawyers. What is needed in the Medicare program are written materials and other unambiguous communications that explain the rules and regulations in a clear and concise manner. It is distressing to see directives from CMS to its carriers that impede the system's delivery of such necessary tools to its participating Medicare providers. For example in a January 25, 2001 Program memo (AB-01-12), from CMS to its carriers, CMS permits its carriers to charge a fee to providers for "reference manuals, guides, workbooks, and other resource materials developed by the contractor designed to supplement or provide easy reference to formal Medicare provider/supplier manual and instructions." For practice managers, the idea that we may now have to pay carriers a fee for access to simplified and reasonable reference materials is difficult to understand. At a minimum, this type of guidance is clearly the wrong direction to take in providing proper education and communication between providers, CMS and the carriers.

PROPOSED SOLUTIONS

There are many more examples such as these that I could share. The system is in dire need of change. But, instead, let me turn to solutions. While these are far from exhaustive, attending to the following would provide necessary first steps toward healing this ailing program.

- Congress should require the Secretary of Health and Human Services (HHS) to publish in the Federal Register, on no less than a quarterly basis, a notice of availability of all proposed policy and operational changes which may affect providers and suppliers including but not limited to changes to be issued through amendments to its carriers manuals and other CMS manuals, or program memoranda, program transmittals or operational policy letters, and of all such policy and operational changes issued in final form during the previous quarter. Simultaneous with publication in the Federal Register, the Secretary should transmit such proposed and final policy and operational changes to its Medicare contractors. The Secretary should require that its contractors notify all providers and suppliers in their service areas of such changes within 30 days of this Federal Register notice. The Secretary should further provide that any changes issued in final form will take effect no earlier than 45 days from the date such final change was noticed in the Federal Reg-

ister. The Secretary should not make a change in policy or operations that affects providers and suppliers without going through the public notice process unless such change is required to meet a statutory deadline or is otherwise required by law. In that event, the Secretary must publish such change in the Federal Register along with the Secretary's justification for issuing such change in a manner other than that required.

• Congress should require the Secretary of HHS to create and distribute a user-friendly manual that contains all the information necessary for Medicare compliance. The manual should be organized, accessible (including on-line), free and updated quarterly. It should contain, in addition to actual regulations and program memorandum, etc., a summary of each issue, Q&A and other explanatory/supplemental material. I would be remiss not to note that as part of its small group compliance guidelines, the Office of Inspector General suggested that small groups create such a document on their own. Can you imagine, if HHS has not even accomplished this task with its many employees, how small medical group practices with few support staff could accomplish such a feat?

• Congress should require the Secretary of HHS to develop a site on the Internet, similar to what HHS has already developed for the Health Insurance Portability and Accountability Act section of their Web site, where Medicare providers and suppliers can post questions and obtain feedback. Responses should be maintained on the Internet site for reference.

• Congress should require the Secretary of HHS to furnish all education and training materials and other resources and services free of charge for providers, eliminating all user fees. The education materials should be drafted in easily understandable language with contact information should questions arise. The materials should be free and accessible on-line.

• Congress should require the Secretary of HHS to make every effort to educate not only the provider community but also its own staff and those of its contractors.

• Congress should instruct HHS to provide better oversight of its contractors to ensure uniform application of national policies and efficient administration of the Medicare program.

• Congress should require the Secretary of HHS to enhance and make public its contractor evaluations. The report should include all components of training, education, auditing and payment. Medicare providers and suppliers should be granted a formal process to provide feedback on the evaluation directly to CMS.

• Congress should require the Secretary of HHS to annually conduct a review of, and report to Congress on, the sources of complexity in the Medicare program as is required of the Internal Revenue Service in Section 4022 of the IRS Restructuring and Reform Act of 1998.

• Congress should provide the Secretary of HHS with the resources necessary to adequately manage the Medicare program without provider user fees.

On behalf of the Medical Group Management Association, I thank you very much for the opportunity to share our thoughts with you today. MGMA realizes that both CMS and its contractors are called upon to accomplish an extremely difficult and complex task. MGMA members and staff are available as resources as you examine and address this critical issue.

Chairman NUSSLE. Thank you very much, I appreciate that. Dr. Bean, my understanding is that Dr. Fletcher wanted to be here in person to introduce you and to welcome you to the committee. He has been called away to—he is involved in another small little health care project, as you may know, and is involved with a meeting with the White House, so he will not be here. But he extends his welcome, and I welcome you and we are looking forward to your testimony.

STATEMENT OF DR. JAMES BEAN

Dr. BEAN. Thank you, Mr. Chairman. I appreciate the invitation and the opportunity to speak to the committee today. And what I am here to talk about is the Medicare regulatory burden and how we have problems dealing with it from the trenches.

I'm a neurosurgeon, and I practice in Lexington, Kentucky, and have been there for 20 years. I want to preface it by saying when I went to medical school, I went to learn to take care of patients

and treat people. The problem is that the time that I have to do that now is dwindling because the time that I have to spend filling out forms and following regulations is growing.

I want to give you some examples, but these are just a few, and it is a problem that plagues physicians around the country.

First, I want to talk about evaluation and management. And we heard a little bit about this before. I will give you a little bit different viewpoint. These are evaluation and management documentation guidelines. These are the reports that I dictate after I see a patient. What I used to do was write a report about what was wrong with the patient and what I was going to do. Now, if it was an easy problem, I would code it as a level 1 or 2, a simple service. And if it was a hard problem, I would code it as a level 4 or 5, a complex service. And if it was in the middle, like most are, it would be a 3, an average.

We heard that doctors have asked for guidelines. In 1995, Medicare issued guidelines on what I had to write in a report to qualify for a given level of service. Now the problem is that HCFA or CMS cannot estimate how hard or easy a medical problem is. So they require that I write down a certain number of lines in each section of the report, whether the information had any relevance to deal with what the problem was. For instance, if it is a level 2 physical examination, I have to go through bullets, lines of items and report on 6 to 11 body parts to make sure it qualifies.

Now, if it is the average, I have to look through and count 12 to 18 body parts and make sure there is some report about that body part, whether it has anything in the world to do with the problem at hand. In order to make the document fit the level of service and comply with the rules, I have to look at grids. It is reproduced in the written report. It is a grid I have to look through and see if I have matched each one with the dictation to make sure I have enough information to qualify for the particular level of service which I have seen as the difficulty of the problem.

If I don't put in enough of these bullets, they tell me I have committed fraud. That is no longer a medical report. That is an accounting document. The value of the service is not related now to the problem I took care of. It is related to the sheer volume of words, the number of lines that I put in the report.

Now, this is wrong. I did not ask for this. Physicians have objected to this format for 6 years. Since 1995, there have been four revisions, and we still do not agree with it. We need to give the medical report back to the doctors and stop using it as a billing statement.

In regard to billing, I send claims to Medicare for the services I do and our Medicare carrier processes them. If we are lucky and they are complete and accurate, they pay them. It sounds easy, but the problem is that the processing is so complex that some get lost entirely, some are rejected by computer edits that I do not have access to and do not know what they are. Some are sent to other insurers without my knowledge, and honestly, some get delayed so long that it costs me more in clerical time to call and resubmit and appeal, that it is cheaper just to throw the claim away.

If I appeal a denial right now in Kentucky, I am told it takes 12 months to get it resolved. It is wrong. It just simply is wrong and

needs to be simplified and needs to be fixed. There are many other comments in my written testimony, but I want to mention one in particular that is not directly Medicare, but it is a HCFA regulation and does apply to Medicare patients, this is the EMTALA regulation. EMTALA is the Emergency Medical Treatment and Active Labor Act. This is a problem alarming to doctors, but I do not think anybody in Congress is aware of it.

The law was passed to prevent patients from being turned away from emergency rooms or transferred somewhere else because they had no money. Congress wrote the law in 1986. HCFA wrote the regulation for the law in 1996. And it so far exceeds the original wording, that it is difficult for me to treat a trauma patient now and exposes them to more risk than existed before the regulation. Let me give you an example.

If I am doing surgery in hospital A in Lexington and I am covering three other hospitals and I may be there 4 hours. And the patient comes to the emergency room in hospital B with a serious problem, I cannot ask for that patient to be sent to me to be treated promptly and if necessary—if it is necessary, to get them into surgery quickly. The regulation prevents that. I am unable to leave the operating room and I am in violation if I do not leave the operating room immediately, and I am in violation if I ask for the patient to be transferred.

If I am found in violation, I will be fined $50,000, and there is no way out of it for me. Every day I schedule a case, and I am on call, that is my risk, because of the regulation.

I have more in the written comments and I thank you for the opportunity to be here. And if there is also anything else I can do to help the committee, I would be glad to.

[The prepared statement of Dr. Bean follows:]

PREPARED STATEMENT OF JAMES R. BEAN, M.D., NEUROSURGICAL ASSOCIATES

Chairman Nussle, and members of the committee, thank you very much for inviting me here today to speak to you about problems that physicians face in dealing with the regulatory burdens of Medicare. My name is James R. Bean, and I am a neurosurgeon in private practice from Lexington, Kentucky. As you all might imagine, when I went to medical school I went to learn how to treat and take care of patients. Unfortunately, the time I spend with my patients is dwindling because of the ever-increasing number of rules and regulations issued by Medicare. Today I will share with you some examples of the effect Medicare regulations are having on my medical practice, although they are the same problems that physicians around the entire country are experiencing.

I am one of four neurosurgeons in our practice, which also employs an additional 19 employees to perform all the necessary medical office administrative functions, such as scheduling, transcription, medical record keeping and billing and collections. I see 30-40 patients per day, 2 or 3 days per week, and perform surgery 8-10 hours per day, 2 or 3 days per week. In additional to my regularly scheduled work, I also serve "on-call" to several hospitals, providing care to patients with emergency medical conditions. I have been in practice in Lexington for 21 years, and have been increasingly frustrated with Medicare's regulatory burden. This burden takes several forms in a physician's office, creating unnecessary delays, expenses, and frustrations without perceptible benefit—either to the patient or the physician. Many of these regulations also expose physicians to potential civil penalties imposed by the Centers for Medicare and Medicaid Services (CMS—formerly HCFA) and the Office of Inspector General (OIG). Whether any benefit accrues to the Medicare program, however, is unclear. If it does, it is at the expense of enormous time, money and effort, which would be better used for treating patients and solving their health problems.

MEDICAL DOCUMENTATION

Evaluation and management (E&M) services are physician office or hospital visits that do not include a procedure, such as surgery. E&M services are categorized according to the AMA's Current Procedural Technology or CPT coding system. Visits are classified according to the location of the service and the type of service performed, such as new office visit, follow-up visit, new hospital consultation, follow-up hospital visit, and so on. Each type of code has 3 to 5 levels of complexity, ranging from simple to highly complex, with the more complex codes paid at higher rates. In my practice, E&M services account for roughly 70 percent of all the services that I provide.

An E&M service involves a history, a physical examination, and an assessment and a plan of action (medical-decision making). Following the visit with the patient, the physician documents this E&M service in the medical record, which is meant to convey the important medical information about the patient, the problem he or she is experiencing, and what course of treatment is required. The sole purpose of the medical record should be to remind the physician and office personnel later of what was found and decided that day, and to communicate this information to other physicians who need to also evaluate and treat the patient.

Beginning in 1995, however, Medicare began to define what particular items had to be included and documented in the medical record in order to qualify for payment at a particular level of service. Because of physician objections to the confusion and complexity of the rules, the requirements were revised in 1997, 1999 and 2000. Each time physicians objected just as strongly to the requirements as being burdensome, confusing and not reflective of the practice of medicine.

Medicare's E&M Documentation Guidelines are most objectionable because they require "bullet counting" of clinical elements necessary to be included in the medical record, whether or not those items have any relevance to the patient's problems. For example, the neurological physical examination section has 21 items. Each level of service has a requirement for notes about an arbitrary number of items, such as 12 items for a middle level (level 3) office evaluation and 6 items for a level 2 evaluation, regardless of whether the information is helpful in understanding the patient and the problems.

In order to make the document fit the level of service and comply with Medicare rules, I have to examine a complex series of grids with each dictation to see if enough information has been included in the medical report. In order to attempt to comply with this system, physician offices have attempted to design standardized templates and reference guides, but these are often just as incomprehensible as the underlying regulations. I've attached a sample template, which illustrates just how complicated this system is.

Medicare's E&M Documentation Guidelines have tried to transform the medical record into a billing and accounting document. The Guidelines do not reflect the actual practice of medicine. They are so complex and inflexible that physicians have to spend extra time adding extra information that is not medically relevant, in order to avoid rejection of the claim or the accusation of fraud. When determining the appropriate level of E&M service, there are no right or wrong answers, but only shades of gray. From a doctor's point of view this is appropriate so we can ensure that the system has enough flexibility so clinical differences can be captured in the medical record appropriately. Unfortunately, these guidelines have attempted to apply a black and white approach, which appeals to the regulators and auditors. The art and science of medicine cannot always be described to satisfy the non-physician auditor, while at the same time satisfying doctors' and patients' medical needs.

I understand that HHS Secretary, Tommy Thompson, has requested that CMS place this project on hold, so we take a step back and reevaluate the kind of documentation system that is necessary. I, personally, would welcome this review and urge the Committee to support this review process so a new more workable system can be developed.

PROCEDURE CODING AND BILLING

All physician services are identified by a CPT code for purposes of billing Medicare. There are over 8,000 CPT codes describing all the various medical procedures currently in use. For instance, the CPT code 61510 is the code for an operation for a brain tumor. Sometimes a second code is used to describe something done during the same surgery, but not included in the description of the primary code. For instance, sometimes a shunt must be placed when the tumor has blocked spinal fluid drainage in the brain. In that case as second CPT code, 62192, would be submitted as well.

The physician office fills out a Medicare claim form with the patient information, the description of the service, and the charge for the service. The claim is submitted electronically or by mail to the local Medicare insurance carrier, who reviews the claim and returns the payment to the physician office. If all the information on the claim form is correct, the claim is processed; if not, the claim is rejected. The claim can be resubmitted by the physician's office with corrections made to the information, or rejections may be appealed.

Medicare uses computer "edits", or screens to identify codes that should not be submitted together. Some edits are simply wrong, either because of misunderstanding by the agency, or just due to human error. To illustrate how frustrating a wrong error can be, I'll relate to you my experience with a claim for burr hole drainage of a subdural hematoma (blood clot on the brain), where the local Medicare carrier rejected CPT 61154. The rejection code (CO-97) indicated that the "payment is included in the allowance for the basic service/procedure." This obscure language means that the service payment is included under another procedure code submitted at the same time, termed the primary procedure. The absurdity is that there was no other code or primary procedure submitted and 61154 was the primary code. Since the computer glitch prevents recognition of 61154 as the primary code, it cannot accept the claim and no payment can be made. Our office called the Medicare carrier and was told that this was a "system error" and that the bill could be resubmitted. There was no assurance that the computer error would be eliminated or that the claim would not be rejected again.

Claims payments are rejected for numerous other erroneous reasons. Often Medicare identifies a second payer it believes should be the primary payer, such as auto accident insurance, and the claim is forwarded without notification of the practice. In our practice, we had an instance of Medicare identifying a Workers Compensation carrier claim as the primary payer through the existence of a 30-year unsettled claim. That service was never paid by anyone. Usually there is little recourse. If a rejected claim is appealed to our Medicare carrier, the current delay in resolving the claim in Kentucky is approximately 1 year.

The time spent by office personnel on resubmitting and appealing claims often costs more than the amount of payment received, even if the resubmission or appeal is successful. For many claims this means it is less expense to the practice to forget the claim than to use personnel time on repeated telephone calls and repeated claim submissions. We have examples of claims resubmitted 8 or more times, with or without final payment. We have examples of claims simply lost by the Medicare carrier or receipt never recorded. When the claim is not acknowledged to have been received within 120 days of service, it becomes ineligible for processing, and payment is never made.

The ever-changing rules for submitting claims are so extensive and labyrinthine that nobody can keep track of them all, or of the changes made each year. There are 6 different categories of laws and regulations that I am expected to know, and each involves hundreds and even thousands of pages.

1. Federal statutes
2. CMS Regulations
3. Medicare Manuals & Program Memos
4. Medicare Carrier & Intermediary Policies
5. Bulletins & LMRPs (Local Medicare Review Policies)
6. Generic Rules (e.g. CPT coding rules)

The rules in levels 2-6 sometimes conflict with each other, so that it becomes literally impossible to remain in compliance with the rules. Certainly a reduction in the number of irrational and conflicting rules is not just reasonable, but urgent. CMS should also standardize the timetable for releasing new rules and regulations (for example on a quarterly basis), so physicians can better keep-up with the requirements of these rules. In addition, CMS has an absolute responsibility in educating physicians about these rules and regulations so they are able to be compliant.

PHYSICIAN CREDENTIALING

Physicians who apply to participate in the Medicare program must submit an application. Applications from hospitals for privileges and private insurers for participation are common. The application required by the Medicare program is the lengthiest and most difficult to understand of any that a physician must complete in the course of practice. The application form has 10 pages of instructions explaining how to fill out the form, and 17 pages in the application itself.

The rules of the application are still confusing, despite, or perhaps because of the lengthy instructions. As an example, an application for a physician assistant (PA) who joined our practice in November 1999 took until November 2000 to be approved.

The application was returned several times before the problem could be understood and resolved. The problem turned out to be that the PA had different Medicare Personal Identification Number (PIN) assigned to the PA while working several years before at another practice. The carrier was unable to simply inform our practice that a prior PIN number in their records was the source of conflict. We therefore had to fill out a different application form.

This is one area that the Committee should recommend CMS make some changes.

EMTALA REGULATION

The Emergency Medical Treatment and Labor Act, or EMTALA, was passed in 1986 in response to reports of patient "dumping", or transfer from one hospital to another because the patient lacked insurance coverage. While certainly laudable in its purpose, since it was passed, CMS has issued a series of regulations related to EMTALA, which have expanded the scope of the law increasing the burdens on physicians to comply with the complex requirements of these rules. In addition, in some instances, the regulations make it more difficult to provide effective treatment, and rather than protecting patients the rules may actually endanger them.

Lexington has 4 hospitals for which our practice covers emergency call. When I receive a call for an emergency transfer from a hospital outside of Lexington while I am performing surgery, the patient is transferred to the hospital at which I am operating. If the patient arrives while I am still in surgery, the patient can be stabilized and evaluated in our emergency department and diagnostic scans are performed, which I can review while I am still in surgery. Once I decide if emergency procedures are necessary, I can make arrangements for treatment, and even prepare that second patient for emergency surgery, to follow the case I am completing. With the patient at the facility where I am operating, I can make decisions and arrangements that prevent any delays in treatment.

If, on the other hand, I receive a call from one of the other hospitals in Lexington for an emergency patient with a similar problem, and the most efficient treatment would be to have the patient transferred to the hospital at which I am operating, EMTALA regulation defines the transfer in this case as a dumping violation, so treatment decisions are delayed until I can finish the surgery, travel to the other hospital, see the patient, arrange new diagnostic studies if needed, and arrange for emergency treatment, even possibly surgery. This enforced delay could result in additional injury that could have been avoided if the in-city transfer had been permissible.

In addition, I am also potentially liable for not responding to the second hospital, even though I may be at hospital one performing surgery and unable to respond. In order to strictly adhere to EMTALA regulation as written, I would be unable to schedule or perform any surgery during the days I am scheduled for emergency call at any of the 4 hospitals. This would allow me to arrive at any of the 4 hospitals within 30 minutes of being called. It would also reduce my availability for routine surgery by 25 percent. If I were a solo neurosurgeon in a town with only one neurosurgeon, I could never perform elective surgery without being in violation of EMTALA's availability rule. It is the most inefficient and wasteful way to manage the time and availability issue, it ignores common practice that worked prior to the regulation, and creates unnecessary risks both for the patient and the surgeon.

There are other examples of the absurdity of the application of this regulation. One hospital at which I perform surgery commonly utilizes an MRI scanner separated from the hospital grounds by ½ block. Often patients who come to the emergency room at that facility need an MRI scan to decide on proper treatment. Accomplishing the scan requires an ambulance to transfer the patient the ½ block to obtain the scan and return to the hospital emergency department. That process constitutes a "transfer" under EMTALA regulation and a violation of the rules. In short, the process of obtaining the necessary emergency diagnostic studies requires a violation of EMTALA regulation.

I seriously urge the Committee to explore in detail the complexity and burdens of the EMTALA regulations, and the potential damaging effect that they are having on patients, physicians and hospitals alike.

Thank you for your attention and the opportunity to relate a few of the very real and onerous problems that CMS regulation has created in my daily medical and surgical practice. I look forward to being a resource to the Committee as you evaluate solutions to these and other problems. These examples are, of course, only the tip of the iceberg, and comprehensive change in how CMS operates would likely address most, if not all of these.

Chairman NUSSLE. Dr. Moon, thank you and we are pleased to accept your testimony now.

STATEMENT OF DR. MARILYN MOON

Ms. MOON. Thank you, Chairman Nussle. I am very pleased to be here today. This hearing has been an interesting one in terms of raising many of the very practical issues facing the Medicare program. I was particularly pleased that so much attention is being focused on the current traditional Medicare program, which currently serves 86 percent of all Medicare beneficiaries, and for a very long period of time to come, will be the main source of coverage for most seniors and persons with disabilities. So as a consequence, the emphasis on improving this basic part of the program, is very important.

My testimony today examines the principles that were laid out by the Bush Administration regarding Medicare reform. As yet, these principles are not very well fleshed out. Someone has to interpret them consequently. I focus on four issues that derive from those eight principles.

The first is the need for improved benefits. The promises for only an option for drug benefits concerns me from the Bush Administration principles. Further, there are a number of issues regarding additional coverage beyond drugs that have come out in the testimony today. Some of the questions raised today indicate that major modernization for Medicare requires comprehensive coverage.

One of the key issues facing the Medicare+Choice plans is that many of them feel they cannot offer a good benefit for individuals unless they offer more comprehensive services than the Medicare coverage services. So though these plans may be paid enough, for example, to offer Medicare coverage services, they are not paid enough to offer additional benefits. They believe that extra benefits, such as prescription drugs, are necessary. And the answer to the question about oral drugs for people with end-stage renal disease is a very simple answer. These drug supplements are not covered when they are taken orally because fear of the slippery slope. If you offer prescription drugs in that instance, why not in other instances?

It is very difficult to manage or control a health insurance program unless you have good comprehensive coverage. It is difficult to imagine, for example, having good disease management or other coordination of care if you cannot say to people, "You should take this prescription drug and it is covered." If you say, "you should take this prescription drug, and I hope you can find a way to get coverage," you are going to have problems with that program.

The second issue raised in the administration's principles is how to structure the program over time. Here my concern is to make sure that the solutions that ultimately get proposed actually resolve Medicare's real problems. There are often unrealistic expectations that the private market will do better than traditional Medicare, for which there is little or no evidence. And moreover, the problems with the market for Medicare+Choice suggest that a number of issues need to be resolved before we move wholeheartedly into that area.

The issue of regulations also is relevant in this area. How good will protections for beneficiaries be? I do some work with the Medicare Rights Center in New York which runs a national HMO hotline for beneficiaries. Those on Medicare have problems that range

from the very simple issue of what to do about extra bills that they should not be receiving and shouldn't pay if they are in a HMO. This can be resolved easily. More serious are denials of services that are clearly covered under the Medicare program, but the HMO chooses not to cover. And after the HMO covers a service for one individual, 3 weeks later the HMO is again refusing to cover it for another individual. So one of the issues about regulations and control is to make sure that the protections are there for beneficiaries if there is to be a greater reliance on these private plans.

The third issue raised by the Bush Administration's principles is to strengthen the program's financial security. We have already heard a lot about this today. Mr. Walker made very good points about solvency sometimes being a distraction from some of the key issues. We are going to have to, as a society, make very hard choices about this program. The number of people covered by the program is going to double. The share of the population covered by the program is going to go from 1 in every 8 to 1 in every 5. It simply is not easy to deal with these changes through greater efficiency or reducing fraud and abuse. Moreover, the program now covers only about 50 percent of the health care costs of seniors and persons with disabilities, so it is not a generous program. One way or another, people are going to have to get care and one of the questions is how as a society are we going to share that.

Finally, I have little to add in terms of management and regulatory changes after hearing the very dramatic testimony from a number of witnesses today, except for the plea to keep in mind that beneficiary needs are important here as well. Information is the biggest gap for beneficiaries right now. The organizations that do counseling for seniors do a very good job, but they do it on a shoestring and can help only a few. Modernization and improvement, and getting rid of unnecessary regulations are important goals. But we are going to have to put money behind this system if we want to see real improvements.

When you think about all the things that need to be done, my conclusion is that it is going to take additional resources. And as a society, we are going to have to decide how to do that in a fair and reasonable way, protecting beneficiaries who currently are in the program and for the foreseeable future who will need our help. Thank you.

[The prepared statement of Ms. Moon follows:]

PREPARED STATEMENT OF MARILYN MOON, SENIOR FELLOW, THE URBAN INSTITUTE

Chairman Nussle, Congressman Spratt, and members of the committee: Thank you for the opportunity to testify today on Medicare reform issues. My testimony today examines the eight principles for reform of the Medicare program recently put forth by the Bush Administration. These principles essentially raise four specific issues that I discuss below:

- The need for improved benefits, including prescription drugs;
- How the program should be structured in the future;
- How to strengthen the program's financial security; and
- Management and regulatory changes to improve the operation of the program.

More details on these principles are needed to understand the intent of the administration, but they do address the range of issues that need to be considered in reform. However, in much of the initial discussion of these principles, beneficiary concerns are raised mainly in the context of expanded coverage. But beneficiary concerns should be a part of each of the issue areas; indeed, the program is intended

to aid seniors and persons with disabilities and that should be at the forefront of debate about Medicare's future.

IMPROVED BENEFITS

The first two principles outlined by the Bush Administration were for the option of a prescription drug benefit as part of a modernized Medicare, and for better coverage for preventive care and serious illnesses. Prescription drug coverage is a major concern and one on which there seems to be considerable agreement. However, this principle only promises an option for such coverage, implying that it would likely require an expensive premium contribution from beneficiaries and hence would not be universal. The second principle refers to coverage of certain screening and preventive services that could be further expanded, building on changes that have already been made in this area. But even more important, a goal of better coverage for serious illnesses refers to adding protections for beneficiaries who incur substantial expenses, usually done by placing a cap on total out-of-pocket spending (referred to as stop loss).

The inadequacy of Medicare's basic benefit package is now well known. Beneficiaries have had to scramble to fill in the gaps by supplementing Medicare with Medicaid, employer-sponsored insurance, Medicare+Choice enrollment, and/or private supplemental plans (Medigap). As a consequence, health care delivery for beneficiaries becomes complex and it is not always efficiently delivered since many of those with extra coverage have most of their cost sharing filled in as well. Further, those who rely on Medigap or who have no coverage experience very high out-of-pocket costs for meeting their health care needs.

It is not surprising, then, that proposals to reform Medicare often include changes in the benefit package. However, such changes are sometimes viewed as a means for generating savings for the Medicare program. Since Medicare only covers a little over half of the health care expenses of the enrollee population and most beneficiaries are spending a rising share of their incomes each year on health care, it is difficult to "improve" the benefit package for beneficiaries in a way that saves costs. Unless additional taxpayer dollars are put into the program, few would benefit from such changes.

For example, even the commitment of $300 billion over 10 years for a prescription drug benefit will cover only about 23 percent of the spending that is expected by beneficiaries on drugs over the next 10 years. It is simply not possible to satisfy demands for a good drug benefit without more resources than what has been allocated at present. Beneficiaries will be very disappointed with this level of spending since it will do little to protect them from high out-of-pocket costs in the future. If drug spending costs grow at 10 percent per year, beneficiaries will face expenses of nearly $4500 by 2010. Private supplemental coverage is not adequate and likely will deteriorate as employers and HMOs pull back their drug coverage and Medigap premiums become prohibitively expensive. Further, beneficiaries' incomes will grow at a rate much less than 10 percent each year, causing them to devote an ever higher share of income to drug expenses.

Adding prescription drug coverage to Medicare offers an opportunity to finally improve the overall benefit package, but this would increase taxpayer costs. From society's standpoint, care would be delivered more efficiently, but the public burden would rise. Any such plan likely needs to offer stop loss, keep the deductibles from becoming a barrier to care, and avoid changes that would burden the sickest beneficiaries. In particular:

- A combined A/B Medicare deductible would result in many people facing higher costs. While persons hospitalized would benefit from a combined deductible of $500, for example, five out of every six beneficiaries would not. Inattention to affordability issues may create problems with access to care. A high deductible on physician services, for example, may discourage some beneficiaries from getting needed care in a timely manner.
- It is probably simpler to retain two deductibles, adjusting their relative levels, than to combine them. This is consistent with the practices of many private plans, including those in FEHBP. The burden from the hospital deductible could be reduced and the Part B deductible increased without creating as much of an imbalance between those who have no hospital stay and those who do.
- Any change in the benefit package to eliminate the need for Medigap coverage is not feasible unless it contains stop loss protections—that is, a guaranteed amount above which the government (and not the individual) pays for any additional cost sharing. The problem with stop loss has always been that when it is low enough to be attractive, it becomes very expensive. For example, many private plans have

$2000 or $2500 limits on out-of-pocket expenses. Under Medicare, a less costly limit of $4000 would probably not get many people to forego other insurance.

• If cost sharing is added to home health or to the early parts of a hospital or skilled nursing stay as some have suggested, costs would rise substantially for the sickest and poorest beneficiaries.

• High option/low option approaches could leave many moderate income individuals in the low option plan if the premiums are high for a better benefit package. This would largely defeat the purpose of offering an improved benefit package. Particularly if drugs are only in the high option portion, this approach would likely lead to risk selection (in which individuals with high drug expenses disproportionately enroll in the high option plans)and other problems for creating a well run program. As an essential part of the treatment of health care, drugs are now integral to care and should be part of a basic benefit package. Would we consider a low option plan that excluded hospitalization, for example?

• Low income protections need to be expanded and perhaps moved into Medicare itself if premiums go up to add drugs to the benefit package.

Finally, another important issue relating to the goal of improving benefit coverage is whether such changes will or should be held hostage to other changes in Medicare. Good care either in fee-for-service Medicare or under private plan options requires comprehensive coverage of essential health care goods and services. This includes prescription drugs. It does not matter what shape reform takes, the need for improved coverage will still be there. And, in fact, adding drug coverage is a necessary element to reduce risk selection problems and to allow better management and coordination of care.

RESTRUCTURING THE PROGRAM TO ADD MORE INSURANCE OPTIONS

This issue incorporates the third and fourth principles offered by the Bush Administration. The third principle is a promise extended only to persons above a certain age that the traditional program would remain as an option. Presumably this means no improvements in the benefit structure such as those described above; such improvements would only be available to those in private plans and perhaps to beneficiaries paying a substantially higher premium for a high option fee-for-service benefit. Over time, the principles imply that traditional Medicare benefit would be eliminated. The fourth principle promises more options like those available to Federal employees. Together, this suggests major emphasis on a premium support or a managed competition approach with a much larger role for private plans.

Health care analysts have long raised the potential benefits of encouraging coordination and flexibility of care in a capitated setting, giving plans incentives to find the least expensive ways to deliver care within a budget. In theory, this should reduce the overuse of services associated with fee-for-service medicine and offer opportunities to insurers to try out new approaches. And, if there is price competition, economic theory would suggest that this will keep the pressure on plans to be attractive to potential enrollees, increasing their market share and delivering care efficiently.

But in practice, will this really mean an improvement in health care for Medicare beneficiaries? In Medicare, FEHBP, and private insurance in general, problems with managed care and the market for insurance cast doubts on how well such a system would work. In Medicare, for example, such plans fail to save the Federal Government any money because of the cream skimming of low cost beneficiaries. Nonetheless, plans have engaged in many activities that put beneficiaries at risk. Supporters of private options often put the blame for problems with Medicare+Choice on HCFA's management. The problems facing Medicare+Choice have a complex set of causes, but cannot be explained away only by poor management by government.

Plans are attractive to beneficiaries because they offer additional services. In fact, the ads that many plans run suggest the importance of vision, dental and drug coverage and mention only in small type that care must be received in network. Since plans have received payments higher than necessary for Medicare-covered services and because they may be providing those services at lower costs, they have been able to subsidize their offerings of additional benefits. But, over the last 3 years, these extra benefits have been substantially reduced in many plans. For example drug coverage has declined from 84.3 percent in 1999 to 70 percent having such coverage in 2001. Withdrawals have left a number of beneficiaries scrambling to enroll elsewhere or to get Medigap coverage if they return to traditional Medicare. And when drug coverage has been retained, stringent caps have been applied or substantial premiums levied on the beneficiary. The cross-subsidy for these extra services has been reduced. Plans and beneficiaries have come to depend upon subsidies not available to those in traditional Medicare, creating troubling inequities.

In addition, beneficiaries have not been treated well by some of the private plans. Private plans have sometimes sought to save costs by limiting access to new technology, to exclude from their plans sub-specialists with considerable experience in treating certain types of illnesses, and to put in place other barriers to getting care. If done carefully and with appropriate medical practice in mind, these methods may be a successful way of holding down costs. But, many researchers have concluded that these are sometimes arbitrary or problematic barriers. The "flexibility" available to plans can be problematic and that at least in some cases, patients do not have access to all Medicare-covered services. Ironically, these examples illustrate denial of "choice" in a form that is likely to be of more importance to beneficiaries than what is often touted as an advantage of private plans offering "choice."

The organizations that contract with Medicare to provide counseling and information or who run specific hotlines for Medicare beneficiaries often find a disturbing pattern of denials of care. Plans routinely deny claims that have minor errors, with no explanation to beneficiaries. But most important, when people are sick, and least able to battle the system, arbitrary rules and the "flexibility" that plans utilize can result in egregious cases of denials. Plans are supposed to cover all Medicare-covered services, but clients of the Medicare Rights Center, which runs a national HMO hotline, have included people denied a type of cancer treatment specifically approved via a national Medicare coverage determination, for example. Others are sent to physicians only barely qualified to provide specialty care.

In many ways, the Medicare+Choice benefit has been one of the less successful changes that have occurred in Medicare. Despite payments that should be sufficient to compensate plans for the costs of Medicare-covered services, the number of withdrawals of plans and cutbacks in services for those who remain reached a peak at the end of 2000. The resulting disruptions for beneficiaries have been problematic. At present, the program is neither saving money for the Federal Government nor achieving good, stable care for many of its enrollees. Private plans certainly have a role to play in Medicare, but many of the issues described above need to be resolved and the current program needs to be working well for beneficiaries before greater reliance is put on private plans under Medicare. The problems go well beyond government management issues.

STRENGTHENING THE PROGRAM'S FINANCES

Assuring Medicare's viability into the future is extremely important. But the Bush Administration set off on a misleading track in its budget submission that suggested that general revenue financing is not a legitimate source of funding for Medicare. This is despite the fact that such financing has been authorized in statute since 1965. Suggestions to combine Parts A and B of the program to generate a new test of solvency effectively use the existence of a trust fund as a means for controlling the costs of the program rather than of protecting it.

If there is a national commitment to Medicare and its future, the level of funding and support needs to be determined on the basis of what is needed to provide reasonable benefits to those eligible for the program. Broader views of financing and solvency are needed in the debate on Medicare's future. According to the dictionary, a program is solvent if it is "capable of meeting financial obligations." If as a society we decide to support the Medicare program, we have the capability of doing so. Hard choices will need to be made about what we want to support as a society, but a new measure of solvency is not helpful unless it realistically balances goals and resources. This cannot be funded out of fraud and abuse reductions, nor from "efficiencies" from the private sector. To serve one in every five Americans in 2025 will require a substantial commitment of resources.

MANAGEMENT AND REGULATORY ISSUES

The last three principles on the Bush Administration's list refer to the appropriate oversight and administration of the program. Although the principles do not raise the issue of resources for such improvements, that discussion is at the heart of the issue. In the 1990's, Medicare became a much more complex program. The private plan option grew substantially so that essentially the Health Care Financing Administration had to oversee two very different types of Medicare programs. It did so in an environment of increased responsibilities beyond Medicare (i.e. SCHIP and HIPAA), of essentially no new resources, and of considerable hostility. In that context, it would have been surprising had HCFA been able to meet the unreasonable expectations placed on it.

A new administration offers opportunities for reviewing old practices and taking a different tack in a number of areas. Improved management would be welcome for the program from all quarters, but the expectations need to be reasonable. Better

information for consumers, measurement of quality, new innovations and demonstrations for improvements in coverage, greater use of the market where appropriate, and adding private sector expertise to the agency will require substantial additional financial resources, more operating flexibility, and de-politicization of an agency that needs to be efficiently run and serve its customers well.

Another major area of concern has been regulatory burdens on plans and providers. But how many regulations are enough? What areas require the most oversight? While it is tempting to throw the current system out and start over again, many regulations continue to be needed to protect beneficiaries. Two types of regulation and oversight are essential: assurances that quality care is being delivered and that beneficiaries have adequate protections for assuring access to covered services. A careful review of existing regulations and requirements should closely examine whether there are enough protections for beneficiaries. Particularly if beneficiaries are locked into private plans by future reforms, the need for oversight will be considerable if abuses now occurring in Medicare+Choice are to be avoided. If beneficiaries are going to be asked to take greater responsibility for care, it is important to have in place appropriate protections and controls for those who are cognitively impaired, frail, non-English speaking, or face other barriers to their getting care. This is a substantially larger group than found in younger populations. In that way, Medicare is different and regulatory needs are also different.

Finally, it is important to note that few private insurance companies escape problems of complexity and bureaucracy. Many patients, both young and old, find the requirements of their plans to obtain approval before getting some services, to determine which doctors and hospitals are in network and which are not, to understand the bills when they come due months later, and to use the appeals process to be cumbersome, complex and overly bureaucratic. Thus, problems with the complexity of our current health care system are by no means inherent only to government. So examining reform from the context of Medicare beneficiaries should consider whether more reliance on private plans will only complicate and confuse beneficiaries further. An assumption is often made that using private plans to provide services will ease the government's oversight burdens, but at what expense to beneficiaries?

CONCLUSION

The principles outlined by the Bush Administration for Medicare reform are to some extent in conflict. Improved financial stability, for example, will be harder to obtain if the benefit changes and management improvements described above are made. And there is little evidence to indicate that reliance on the private sector will save government costs (unless substantial burdens are passed on to beneficiaries). Thus, the first task in fleshing out these principles should be for the administration to indicate its priorities and make clear how much in the way of further resources will be available for improvements.

A broad range of changes in Medicare will be needed in the future to improve the program. But no set of reforms can be expected to run perfectly over time with no adjustments. Medicare's future will likely be rewritten numerous times as health care changes and Baby Boomers move through the system. What is important, however, is to avoid making major structural changes on the basis of theory that may be difficult to undo if the reality falls short of the theory. Beneficiaries are the ones likely to be put at risk in such a situation. Much needs to be done, but improvements in Medicare do not need to be delayed until all the pieces are put into one tidy package.

Chairman NUSSLE. Thank you for your testimony. One of the questions I have—and you bring up a very good point, Dr. Moon, and it is something that does need to be asked because just harping on paperwork and harping on regulations and harping on oversight of our doctors and our health care providers seems to be in vogue, or at least has been today. But the real question is, is the patient better off as a result of having those regulations, those forms, all that paperwork filled out, having the fraud, you know, oversight that we have? And what would be your opinion? Is all the paperwork—are they getting better level of care or quality of care or appropriate care as a result of all that oversight?

Ms. MOON. I think the answer has to be mixed. Where the oversight and regulations and protections are used, for example, to as-

sure that someone in a managed care plan gets the care that is covered, where they are held accountable for quality standards, where HMOs are held for quality standards, beneficiaries are substantially better off.

On the other hand, I do not think any patient wants to deal with a doctor or a hospital that is extremely unhappy with their insurance company or Medicare. None of us want to go to the doctor and feel that he feels he does not have enough time to spend with you because he is not being paid enough, is being harassed by paperwork requirements or whatever. It is a beneficiary issue as well to make sure that we do not overdo regulations.

The new administration should be commended for taking on this very important issue and I am glad to see them spending time on it. I just hope that they take into account the full range of concerns including those of beneficiaries.

Chairman NUSSLE. Well, I guess what I am getting at, and I realize that you cannot use this as a blanket statement in every instance, but we seem to have a one-size-fits-all system, so let us look at that for a moment. I guess what I am saying, who am I going to trust, given the opportunity before me? Am I going to trust either one of these two doctors who I have never met before in my life? If I am in the examination room with you—let us say I have some—and there are a probably a few of them who think I do need my head examined and I realize that not all of you do—but let us assume that is what it is for the moment—and I am in the examination room with Dr. Bean, for example. And I have to trust and the system has to either trust him, has to trust the contractor, has to trust HCFA, has to trust me as a Congressman to manage the system, has to trust lawyers, judges or HMOs or anything you want to trust, who am I going to trust?

And, unfortunately, what we have in the system now is that we definitely do not trust the doctor. We just do not. It is not possible for us to trust the doctor or for us to trust the nurse who is visiting the home health situation for the example that I used—it is amazing the questions that they have to go through. But I don't have them. How is their eye sight? One of them was whether or not—diet, exercise. Exercise? My gosh, the person has got a hip replacement and just got home. There are all sorts of things they are supposed to ask and document. And then I assume someone has the opportunity to read them.

I just do not know how we have gotten away from the system of trusting the professionals who have gone to school and have done the work to put themselves in a position. And the only thing I can come up with is that over time, there have been situations where there has been lack of trust, where a doctor or health care provider of some sort somewhere has done something that has suggested to someone, somewhere, that we got to have a form to fill out in order to manage this, otherwise we are going to be in big trouble.

I guess the question I have for the doctors is, you have seen this metamorphosis over the period of your career. One of you mentioned you had been doing this for 20 years and that the amount of time that you spent in direct patient care versus where you are now is dramatically different. And I guess the question I have for you is give me that in a percentage, when you first started, how

has this changed in the amount of hands-on care versus paperwork back then versus today? Give me a time frame. Dr. Kaplan.

Dr. KAPLAN. I have been practicing internal medicine now for 20 years. And I think when I first started, the vast majority of what I did was spent taking care of patients. There was very little administrative hassle, very little paperwork. The purpose of a required document was to assure good quality continuity of care. Today, I would estimate that for every 2 hours I spend in patient care, an hour is spent in paperwork. And that is not right. It is waste and inefficiency.

My personal opinion is that oversight is critical, but it needs to be driven off of standardization of practices. We need to eliminate the unnecessary variation in waste, freeing up funds and time, which would be able to be better applied to direct patient care.

Chairman NUSSLE. Dr. Bean, how has it changed for you?

Dr. BEAN. I would estimate that I spend 50 percent more time, perhaps 75 percent more time now than I did before. Now part of this is accomplished by hiring more people, both clinical people in my office, whether a nurse practitioner or a physician's assistant or even clerical people. They can do the same things that are being required of me. But still, my personal time, if you ask me how much it has increased, it is at least that much.

I would say a third of it is about right. But that doesn't measure all the time, because those things required of me, I hire the people to do, which now drives the cost of doing business up. It employs people, certainly. But it doesn't do anything for me to take time to care for patients. I come in early and work late.

Let me say something, if you would. One of the features that is interesting about legislators is cutting to the chase, getting through the reams of information and trying to distill it to the core problem. Doctors are very good at that. The problem with the system that we have created here with Medicare is that it penalizes the doctor who does it. It generates and asks for—it rewards reams of information—clouds of information so that you cannot get to the core; you cannot get concise to the point of the trouble and get the job done quickly. That is what we want to do and are trained to do.

Chairman NUSSLE. I am amazed by the story of the audit you had to go through. I have heard similar examples from some of my hospitals. But you put it in much more graphic detail.

One of the things—the last question I have for all of you has to do with this whole balancing between fraud—what is our perception of fraud as if we—I think—I am not sure that we have our arms around it as a result of all the paperwork. And in part, you know, we have created more paperwork. But unless there are people there to monitor every single piece of paper and unless we trust those people who are monitoring the paper and we have monitors on the monitors to monitor whether or not they are monitoring it correctly, do we really have a better system that is rooting out all the waste, fraud and abuse within the system?

And I think Dr. Moon may have had the best idea of all, and that is more patient information. If the patient or the beneficiary, as you stated, had better information so that they could monitor it—I mean one of the frustrations we all have, I think, whenever we deal with providers, doctors, nurses, they speak in a jargon that we

sometimes do not always understand because they are rushed to go out and do that 1 hour of paperwork, we do not always get to ask the questions we want to ask or we feel stupid in asking them. We do not always get the information we need.

So if there is better beneficiary monitoring of their own health care delivery, that might be one of the solutions. But have we been able to, from your—I am not asking you to squeal on anybody—but do you feel that the system that has been created, has done a job that it was intended to do, to root out the fraud within the system or has it allowed it to stay the same or is it arguably worse? And I invite all three of you to answer that.

Dr. KAPLAN. Let me say as a practicing physician and leader of a health care system, I abhor fraud and I speak very clearly to our people about this. We must be in compliance with the law. The problem is that the rules and regulations have become so complex, that it is almost as if fraud or unintended error has been created as a result of the complexities that we are asked to deal with and interpret every day the variability of those regulations are very open to misinterpretation, such as one fiscal intermediary may interpret it differently than another.

I think what has happened is that there is a very small minority of intended fraud going on in this country. And it is unacceptable. It is criminal. But what has happened is a whole system and infrastructure has been built around that such that we are all painted with the same broad brush, and then asked to build that into our daily work life in a way that is a disadvantage to our patients and is driving people out of the profession. One of the things I am most concerned about is that in many marketplaces today, the capacity for providers to provide care is limited. And we are seeing many of our best and brightest young people choosing not to go into health care.

So I think that the unintended consequences of the regulations have been detrimental.

Chairman NUSSLE. Dr. Bean.

Dr. BEAN. I believe, if you will—let me say, my grandfather was a general practitioner in eastern Ohio, a little town called New Comerstown. He was highly respected. He worked hard through his life for 40 years and retired and died in his hometown. He was a respected man by his patients in the community. If he were alive today, he, like me, Dr. Kaplan, and every doctor in this country, would be regarded first as a criminal who has to be proven innocent. The only thing that we lack is an audit of all our practices, and then frequently, repeated to make sure we are still compliant. We are regarded as criminals now and this has happened virtually over the past 6 years since the intensity of OIG investigations has happened.

We have medical centers, respected academic medical centers making huge settlements, so they do not have to face criminal charges when what they need is education and just reform of the way they do their recordkeeping. It is threat and it results in anger and fear. So the relationship between this agency and our profession will remain anger and fear until this whole attitude changes.

Chairman NUSSLE. Thank you. Dr. Moon.

Ms. MOON. The strong emphasis on the costs of health care over the last decade or two and the hope that fraud, waste and abuse elimination can solve our problems has gotten us into this pickle. I would emphasize that many of the studies that have been done that come up with large fraud numbers of 20 percent or 30 percent, refer not to fraud, but refer to waste and abuse. Waste and abuse are extremely difficult to determine particularly in areas in which the standards are unclear and what is necessary or unnecessary are unclear.

The only way to deal with these areas where standards are not clear, is to use massive regulation to reduce waste and abuse or at least that has been the philosophy. That is why home health has been singled out because it is very difficult to know what is necessary care in this area.

When Dr. Bean does neurosurgery or does a particular procedure, that is much easier to document. We have to, as a society, decide whether we want to err a little bit on the side of letting some fraud get through system and trust people or whether we want to make sure we root it out, but in doing so, we drive everybody crazy. We need a better balance. It seems to me for a while, it was probably in one direction, that there wasn't good oversight. We need to have better, smarter oversight and less of it than we have at the present time.

Chairman NUSSLE. Thank you very much. You have all provided, I think, a very excellent contribution to some of the ideas that we need to consider, and I certainly appreciate your willingness to come forward and do that. And I think you are particularly correct, Dr. Bean, when you talk about the adversarial nature of the system. I don't know how anyone, as you have all stated, can do business that way or certainly keep the mission that you all started with when you went to school to serve. It has got to be very frustrating.

I have a number of doctors back home in Iowa that are considering just getting out of it. They made enough money and socked away enough to go away and retire. And every single one of those that does that allows for less care, especially out in my area where it is very rural and yours, too, where you don't have that many choices to begin with. Losing an experienced surgeon or health care provider of any kind, particularly now with the nursing shortage that we have in many places in the country, is devastating to the overall system. As I think Dr. Scanlon said, while we're talking about Medicare today, because Medicare is so involved in all of the delivery of the health care of the country, we are talking about the future of our health care, period, when we talk about the future of Medicare. So I appreciate your testimony. And any final thoughts on the part of the witnesses? If not, we will recess the hearing. Thank you very much.

[Whereupon, at 1:50 p.m., the committee was adjourned.]

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